Arkansas Medical Society's Physician's Legal Guide Sixth Edition

Compiled by Mitchell, Blackstock, Barnes, Ivers & Sneddon, P.L.L.C.

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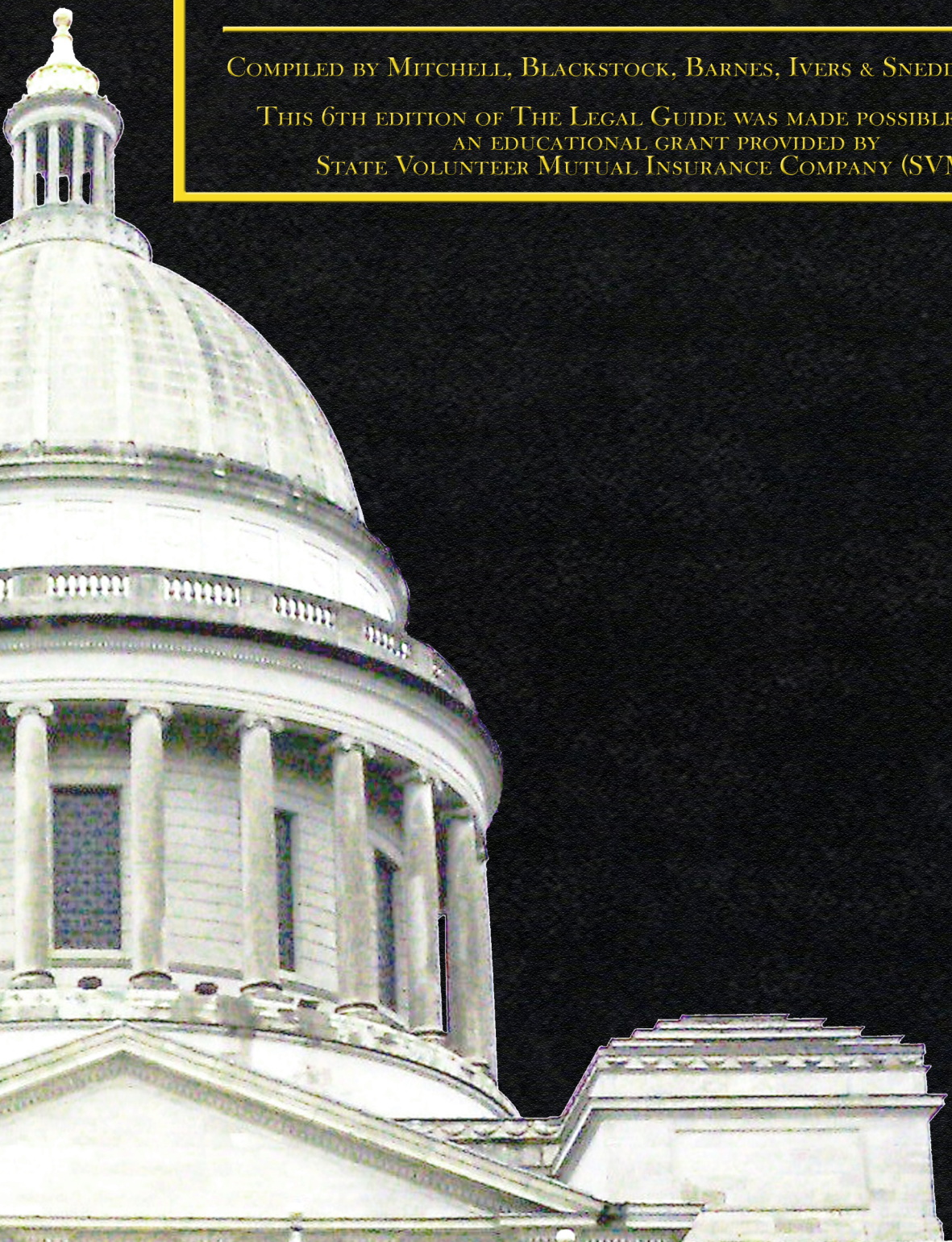

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THE READER IS CAUTIONED TO USE THIS GUIDE AS A BEGINNING REFERENCE ONLY. IT IS NOT A COMPLETE LISTING OF ALL LAWS THAT MAY AFFECT A PHYSICIAN'S PRACTICE. THIS GUIDE SHOULD NOT BE RELIED UPON OR SUBSTITUTED FOR LEGAL ADVICE FROM AN ATTORNEY.

IN SOME PORTIONS OF THIS GUIDE, EXCERPTS FROM THE ARKANSAS CODE ANNOTATED OR STATE OR FEDERAL REGULATIONS ARE QUOTED, WHILE IN OTHER PORTIONS THEY HAVE BEEN PARAPHRASED. CHANGES IN STATUTES AND REGULATIONS OCCUR FREQUENTLY, AND COURT DECISIONS AFFECT INTERPRETATION OF THE STATUTES AND REGULATIONS. LEGAL COUNSEL SHOULD ALWAYS BE CONSULTED FOR SPECIFIC PROBLEMS OR QUESTIONS.

I understand that this guide is a beginning reference that should not be relied upon as legal advice and that legal counsel should always be consulted for specific problems or questions:

☒ YES ☐ NO

INTRODUCTION TO "THE GUIDE"

The Arkansas Medical Society is a non-profit, voluntary professional association representing the physicians of Arkansas and their patients. Founded in 1875, the AMS currently has a membership of more than 4,000 medical doctors (M.D.), osteopathic physicians, (D.O.) and medical students. One of the primary missions of the Society is to educate physicians and the public about laws affecting the practice of medicine. This publication is an extension of that goal.

The Arkansas Medical Society is pleased to present this sixth edition of the ***Arkansas Medical Society's Physician's Legal Guide.*** The first edition, published in book form in 1997, was the first-ever attempt to compile the state and federal laws affecting the practice of medicine in Arkansas. It continues to be the only compilation of its kind in Arkansas. Future updates are planned approximately every two or three years to coincide with new legislation passed by the Arkansas General Assembly.

Once you familiarize yourself with the ***Guide's*** contents, it will become a valuable resource. Physicians, clinic administrators, attorneys and others will benefit from having such a broad array of information at their fingertips. The Table of Contents will give you a broad overview; to search specific terms, click the binoculars link in your Adobe Acrobat toolbar and enter the term you wish to search. If you cannot locate the topic, please contact the AMS for assistance.

The AMS encourages readers to provide comments as well as suggestions for topics to be included in future editions.

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ABANDONMENT

Abandonment of Patient by Physician

Unless altered by contractual obligation, physicians are not required to serve all patients who seek their care. However, once physicians begin to render service, they should not neglect the patient, nor withdraw from the case without first giving the patient or the patient's representative notice and a fair opportunity to secure another physician. *AMA Code of Medical Ethics, § 8.11, § 8.115*.

If the patient can prove an injury related to abandonment or premature cessation of treatment, then the patient can sue for malpractice.
Ark. Code Ann. § 16-114-201.

Abandonment of Newborn

See ADOPTION, PATERNITY AND GUARDIANSHIP, Abandonment of Newborn at page 33.

ABORTION

See Family Planning at page 93.

ABUSE

Maltreatment of Adults

A physician or a hospital providing treatment of any "maltreated adult" may keep the adult in emergency custody for a limited time, whether or not medical treatment is required, in certain circumstances. "Maltreated adult" means one who has been abused, exploited, neglected, physically abused or sexually abused, as those terms are defined under the statute on adult abuse. This emergency custody power does not apply to domestic abuse situations as long as the person is mentally competent and physically capable of leaving the situation in which the abuse occurred. Emergency custody is possible if the circumstances or condition of the adult are such that returning to or continuing at the adult's place of residence or in the care or custody of a parent, guardian, or other person responsible for the adult's care presents imminent danger to the adult's health or safety, and the adult either lacks the capacity to comprehend the nature and consequences of remaining in a situation that presents imminent danger to his or her own safety or has a mental impairment or a physical impairment that prevents the maltreated adult from protecting himself or herself from imminent danger to his or her health or safety. The state Department of Human Services must be notified when an adult is taken into emergency custody, and other requirements apply. Emergency custody must not be over seventy-two (72) hours unless the end of the hours falls on a weekend or holiday.
Ark. Code Ann. § 9-20-114, as amended by Acts 283 and 497 of 2007.

Counselors and Therapists

Changes to the child maltreatment law in 2009 permit certain counselors or therapists to report some sexual offenses against adults to the Child Abuse Hotline. Specifically, the Child Abuse Hotline will accept s report of sexual abuse, sexual contact, or sexual exploitation naming an adult as the victim if: (1) the alleged offender is a child's caretaker, and (2) the person making the report is either the adult victim, the alleged offender, law enforcement, or the "counselor or

therapist" of either the adult victim or the alleged offender.
Ark. Code Ann. § 12-18-306.

See also Reporting, Mandatory Physician at page 216 and Malpractic, Informed Consent at page 155.

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

Free Testing

The Department of Health conducts free human immunodeficiency virus (HIV) and acquired immune deficiency syndrome testing for the citizens of the state.
Ark. Code Ann. § 20-15-901.

Duty to Report

Physicians must immediately report to the Arkansas Department of Health any patient determined to have AIDS or who tests positive for the human immunodeficiency virus (HIV) antigen or antibodies. The report must be made within 24 hours and may be made on the automatic phone answering service at (800) 482-8888. *Ark. State Board of Health's Rules and Regulations Pertaining to Communicable Disease, Section III(A) (Rev. Aug. 1, 2005)*

Other persons required to report positive determinations of AIDS or HIV include: hospital infection control practitioners and chairpersons of infection control committees, directors of laboratories doing business in Arkansas, medical directors of in-home health agencies, program directors of state agencies to whom AIDS/HIV results are disclosed, nursing home medical directors, and those required by regulation. Privileged communication laws still apply.

Physicians who are unable to locate the patient for notification of positive test results must notify the Department of Health. The department provides field agent locator services for patient notification. The department also provides free counseling and notification to individuals possibly infected by the patient.
Ark. Code Ann. §§ 20-15-905 to 906.

Confidentiality

Physicians and their agents who make or receive an AIDS report must maintain confidentiality. The prosecuting attorney, however, may subpoena the reports to investigate or prosecute the offense of exposing another to the human immunodeficiency virus.
Ark. Code Ann. § 20-15-904.

See also, HIPAA at page 115; Medical Records - Confidentiality at page 174; Medical Records - Subpoena of Medical Records at page 178.

Penalties for Failure to Report

Physicians who fail to report a finding of AIDS to the Department of Health could be fined $100 to $500, imprisoned for up to one month, or both.
Ark. Code Ann. § 20-7-101(a).

The Federal Health Insurance Portability and Accountability Act (HIPAA)

In 2005, it wass the position of the Arkansas Bar Association's Health Law Section that the law on mandatory reporting by physicians was a permissible state law under HIPAA and was not pre-empted by the federal law. . Since subsequent revisions to HIPAA, the Health Law Section has withdrawn its prior publication on HIPAA and has not taken a position. Practitioners with any questions on this issue should consult legal counsel.

Patient's Duty

A person who is infected with HIV, must, prior to receiving any health care services of a physician or dentist, inform the physician or dentist of the HIV infection. Failure or refusal to do so is a Class A misdemeanor punishable by up to one year imprisonment and a fine of up to $2,500.

Ark. Code Ann. § 20-15-903, § 5-4-201, as amended by Act 209 of 2009, § 5-4-401.

Pregnant Women Testing

The law appears to mandate that physicians attending pregnant women during their pregnancy take venous blood or "other approved specimen of the woman as early as reasonably possible in the pregnancy" to test for syphilis, HIV, and Hepatitis B. If a woman did not receive prenatal care, then the law states the testing should be done at the time of delivery. However, the law also provides that if a woman refuses to be tested, that refusal "shall relieve the physician of any responsibility [under the part of the law requiring testing]." In any event, physicians have a duty to explain that syphilis, HIV, and Hepatitis B may be transmitted from an infected mother to the fetus or unborn child and that these infections may be prevented if the maternal infection is recognized and treated. Physicians are also duty-bound to provide counseling and instruction on HIV. If the syphilis, HIV and Hepatitis B tests are not performed, the physician must document the fact in the patient's medical record. Only a patient's refusal to have the tests relieves the physician of the responsibility to have the tests performed. Confidentiality rules apply.

However, under another law titled the "HIV Shield Law," informed consent is not required for HIV testing "when in the judgment of the physician, such testing is medically indicated to provide an appropriate diagnosis and treatment to the subject of the test" provided that the subject of the test has otherwise given consent to the physician for medical treatment. The HIV Shield Law states, "Notwithstanding any other law to the contrary, no person who performs a test" when it is medically indicated and the patient has otherwise consented to treatment can be held civilly or criminally liable for performing the test. **See HIV Shield Law, below**.

There is an apparent conflict between the law on pregnant women testing, which allows women to refuse HIV tests, and the HIV Shield Law, which provides practitioners with the authority to perform HIV tests without consent in limited circumstances. It is unclear whether the HIV Shield Law would permit a practitioner to conduct an HIV test after a pregnant woman has expressly refused the test. If the patient were to withdraw consent for all medical treatment, the HIV test could not be performed.

Practitioners faced with a pregnant woman's refusal to consent to testing for HIV, syphilis or Hepatitis B should consult with legal counsel before taking any action.

Ark. Code Ann. § § 20-16-507; 20-15-905.

HIV Shield Law

Consent for an HIV test is not needed in two situations. As discussed above, informed consent is not required when a physician believes HIV testing is medically indicated for appropriate diagnosis and treatment of the patient being tested, as long as the patient has

otherwise consented for the physician to provide medical treatment. The physician must inform the patient of a positive test for HIV. The Shield Law provides that no one who performs an HIV test in these circumstances can be held civilly or criminally liable for performing the test.

No consent for HIV testing is needed when a health care provider or employee of a health facility comes into direct skin or mucous membrane contact with the blood or bodily fluids of an individual who might transfer HIV. The test results must be provided by the person ordering the test to the affected health care provider or employee, to the health care provider's or employee's physician, to the individual tested, and to the individual's physician. Further, appropriate counseling must be provided. "Health care providers" include physicians, nurses, paramedics, and any other person providing such care. "Employees of health facilities" include employees of hospitals, nursing homes, blood banks, blood centers, sperm banks, and other health care institutions.

Improper to Refuse Care

Health care providers and health facilities may not refuse treatment to a patient based on a positive HIV test.
Ark. Code Ann. § 20-15-905.

Civil and Criminal Liability

Civil liability and criminal sanctions may not be imposed for performing HIV testing as described above. Civil liability and criminal sanctions also may not be imposed for disclosure of test results when the results are required to be given to tested health care providers, employees, physicians, and patients as discussed above.
Ark. Code Ann. §§ 20-15-901 to 906.

Duty to Test for Blood-borne Diseases

Individuals or companies collecting blood products for resale or distribution must meet certain mandates. First, they must inform donors that their blood will be tested for HIV and other blood-borne diseases. The results must be provided to the donor. In the case of reactive results, the name of the donor must be reported to the Department of Health. Second, they must agree to use no blood product of that donor until the donor is found to be HIV free by a United States Food and Drug Administration (FDA) approved test. Third, they must repeat any screening test with a positive result. If a repeated test is positive again, it must be further confirmed by a different type of test approved by the FDA. Positive blood shall not be accepted. Finally, they must encourage donors testing positive to seek medical treatment.
Ark. Code Ann. § 20-27-302.

See also, Occupational Exposure to Blood or Other Potentially Infectious Materials at page 193.

Criminal Offenses

The prosecuting attorney may prosecute the offense of "Exposing Another Person to the Human Immunodeficiency Virus" or "Assault and Battery Upon Law Enforcement, Fire Fighter, or Emergency Medical Personnel." If needed, a court may order the suspect to undergo an HIV test. A physician, the Department of Health, or a local health department may administer the test. While the test must be administered confidentially, the testing agency must notify the victim when the test result is positive for HIV or hepatitis. The agency must then refer the victim for appropriate counseling.

The offense of "Exposing Another Person to the Human Immunodeficiency Virus" is a Class A felony, with punishment ranging from a fine of up to $15,000, imprisonment for 6 to 30 years , or both. The offense of "Assault and Battery Upon Law Enforcement, Fire Fighter, or Emergency Medical Personnel" is a battery in the second degree, which is a Class D felony. A Class D felony is punishable by a fine of up to $10,000, imprisonment for 3 to 10 years, or both. *Ark. Code Ann. § 5-14-123; 5-4-201, as amended by Act 209 of 2009, 5-4-401; §5-13-302(a)(4), as amended by Act 827 of 2007, Acts 344 and 689 of 2009.*

Physicians with HIV/Hepatitis B/Hepatitis C

Congress has required states to establish guidelines to apply to health professionals in order to prevent the transmission of HIV, Hepatitis B or Hepatitis C virus during exposure-prone invasive procedures except for emergency situations. A physician or physician's assistant who performs or participates in an invasive procedure or performs a function ancillary to an invasive procedure shall be familiar with, observe and rigorously adhere to both general infection control practices and Universal Blood and Body Fluid Precautions as recommended by the federal Centers for Disease Control to minimize the risk of transmitting HIV, Hepatitis B, or Hepatitis C from a physician to a patient, from a patient to a physician, or from a patient to a patient. Adherence to the Universal Blood and Body Fluid Precautions requires observance of certain minimum standards, including use of protective barriers, requirements on sterilization, resuscitation, disinfection and handling of needles, scalpels and other sharp instruments.

Regulation 16 of the Arkansas State Medical Board establishes guidelines for physicians with HIV, Hepatitis B or Hepatitis C. An exposure-prone procedure means an invasive procedure in which there is a risk of percutaneous injury to the physician by virtue of digital palpation of a needle tip or other sharp instrument in a body cavity or the simultaneous presence of the physician's fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site, or any other invasive procedure in which there is a risk of contact between the blood or body fluids of the physician and the blood or body fluids of the patient.

A physician who is HIV positive, has tested positive for Hepatitis B or C, or who otherwise knows or should know that he carries and is capable of transmitting HIV or Hepatitis B or C, shall not thereafter perform or participate directly in an exposure-prone procedure except in certain circumstances. A physician may participate in an exposure-prone procedure with a patient when each of the following four conditions have been met:

1. The physician has affirmatively advised the patient or the patient's lawfully authorized representative that the physician has been diagnosed as seropositive for Hepatitis B, Hepatitis C and/or HIV, as the case may be.
2. The patient or the patient's representative has been advised of the risk of the physician's transmission of Hepatitis B, Hepatitis C and/or HIV to the patient during the exposure-prone procedure. The physician shall personally communicate the information to the patient or the patient's representative. The physician shall also communicate such information to the patient's referring physician.
3. The patient or the patient's representative has signed a written instrument stating:
    a. The identification of the exposure-prone procedure to be performed by the physician;
    b. An acknowledgment that the advice required has been given to and understood by the patient or the patient's representative; and
    c. The consent of the patient, or the patient's representative, to the performance of or the participation in the designated procedure by the physician.
4. The physician's Hepatitis B, Hepatitis C and/or HIV seropositivity has been affirmatively

disclosed to each physician or other health care personnel who will participate or assist in the exposure-prone procedure.

Consent may be revoked by the patient or his representative at any time prior to the performance of the procedure by any verbal or written communication to the physician expressing an intent to revoke, rescind or withdraw the consent.

Reports and information furnished to the Arkansas State Medical Board on the Hepatitis B, Hepatitis C or HIV status of a physician shall not be deemed to constitute a public record but shall be maintained by the board as confidential and privileged as a medical record and shall not be subject to disclosure by means of subpoena in any judicial, administrative or investigative proceeding provided that the physician adheres to the rules and regulations of the Medical Board and is willing to subject himself to counseling, review and monitoring by the board or its designated agent.

Upon the board learning that a physician is Hepatitis B, Hepatitis C or HIV seropositive, the board or its agents shall make contact with the physician, review the rules and regulations of the board and set up a process of monitoring that individual's practice.

The monitoring of physicians and disciplining of physicians will be reported to the Arkansas Department of Health but will remain confidential.

If the physician does not comply with the rules and regulations of the board, he will be deemed to have been "grossly negligent and committed ignorant malpractice" and to be physically incompetent to practice medicine to such an extent as to endanger the public. He will be subject to a disciplinary hearing and possible sanctioning of his license.
Ark. State Medical Board Regulation 16, as amended in 2003.

Financial Assistance for HIV or AIDS Medications

The HIV or AIDS Medications Act provides for distribution by the Arkansas Department of Health of "medically necessary" HIV or AIDS medication to Arkansas citizens without ample resources or available avenues to acquire medications. The legislature specifically found that Arkansas citizens suffering from HIV or AIDS should have access to the latest drug therapies and that proper treatment of those individuals is in the public interest. However, the Act subjects the furnishing of financial assistance to the availability of funds. For further information on payment assistance, contact the Arkansas AIDS Foundation at (501) 376-6299 or by mail at P.O. Box 1208, Little Rock, AR, 72203.
Ark. Code Ann. § 20-15-907,and following.

ACUPUNCTURE

Acupuncture is the use of needles, and other modalities, at specific locations on the body for the prevention or treatment of various conditions by controlling the flow and balance of energy. An acupuncturist is a person licensed by the State Board of Acupuncture and Related Techniques.

If certain requirements are met, an acupuncturist who has been certified by the National Commission for the Certification of Acupuncturists may be licensed in Arkansas by the board without an examination. An acupuncturist who is not certified by the national commission may receive a provisional license from the board subject to the condition that the acupuncturist becomes certified by the national commission within two years of the effective date of this Act. During the provisional period, the acupuncturist may practice acupuncture within the scope

determined by the board in writing after review of the acupuncturist's qualifications.

An application may be obtained from the State Board of Acupuncture and Related Techniques. In addition to completing the application, the applicant must produce two affidavits from reputable acupuncturists who attest to the applicant's good moral character; have completed not less than 60 semester credit hours of college education, including a minimum of 30 hours in a science field; and have completed a program in acupuncture and related techniques as evidenced by a certificate or diploma from an institute approved by the board. The program must cover a period of not less than four academic years and include a minimum of 800 hours of supervised clinical practice. In addition to other fees, the board may charge an application fee of up to $250 and an examination fee of up to $350. Licenses are renewable every two years upon the payment of a fee and completion of at least 24 hours of continuing education.

Licensed health care professionals may practice acupuncture when permitted to do so by their state licensing board. However, a chiropractic physician must complete an educational program in acupuncture from a college accredited by the Council on Chiropractic Education.

A person who violates the provisions of this law is guilty of a misdemeanor, and may receive a fine between $1,000 and $5,000, and/or a prison term between one month and eleven months.

Acupuncturists are not permitted to prescribe, dispense, or administer legend drugs nor are they permitted to administer an injection of a substance.

If an acupuncturist refers to himself or herself other than as a licensed acupuncturist, certified acupuncturist, acupuncture practitioner, or Oriental acupuncture practitioner, or identifies himself or herself as a doctor or physician, this constitutes false advertising and is grounds for disciplinary action by the State Board of Acupuncture and Related Techniques. Disciplinary action can constitute any of the following: refusal to issue a license to the offender, revocation or suspension the offender's license, restriction the practice of the offender, an administrative fine of up to $5,000 for each offense, reprimanding the offender, or probation for a period of time and subject to such conditions as the Board may specify.

Ark. Code Ann. §§ 17-102-101 to 313, as amended by Act 1461 of 2009. Ark. Code. Ann §§17-102-312 to 313.

ADOPTION, PATERNITY AND GUARDIANSHIP

Adoption

Who Can Place a Child for Adoption

Generally, persons or entities placing children for adoption must be licensed by the Department of Human Services, Division of Children and Family Services. However, physicians and lawyers may facilitate an adoption without being licensed by DHS, as long as they are licensed to practice medicine or law in Arkansas. *Ark. Code Ann. § 9-28-402(7), as amended by Act 634 of 2007 and Act 723 of 2009*. (Physicians should be aware that since health care providers are entities covered by the federal Health Insurance Portability and Accountability Act (HIPAA), they must follow HIPAA rules for disclosure of Protected Health Information (PHI) in connection with an adoption.) ***See HIPAA at page 115.***

Physicians who have identified prospective adoptive families commonly work with attorneys to begin the adoption process. These private placement adoptions are subject to the same restrictions and safeguards as are agency adoptions. Thus, physicians and attorneys must still obtain consent from the appropriate party, give notice to certain parties of the adoption proceedings and hearings, perform a home study, collect expense affidavits, provide for the disclosure of non-identifying health history information of the birth parents, ensure the presence

of the adoptive child and the adoptive parents at the hearing on the petition, and ensure the issuance of a substituted birth certificate.
Ark. Code Ann. §§ 9-9-201 to 506, as amended by Act 539 of 2007 & Acts 230 and 724 of 2009.

Confidentiality

All information relating to an adoption, except as provided by law or following a court order, must be kept confidential. *Ark. Code Ann. § 9-9-217.* Any agency, organization or other person who "knowingly" or "negligently" allows an employee to disclose this information is guilty of a Class A misdemeanor. Knowingly can be defined as "with awareness, deliberateness or intention." Negligently can be defined as "without exercising that degree of care which a person of ordinary common sense and prudence, under like circumstances and in the performance of a like act, would have exercised."
Ark. Code Ann. § 9-9-502.

Surrender of Custody by Hospital or Birthing Center

Before a hospital or birthing center releases a minor child to a person claiming to be the adoptive parent or the adoptive parent's attorney or agent, the hospital or birthing center must obtain a written release signed by the biological mother of the minor child, witnessed by two credible adults and verified before a person authorized to take oaths directing the hospital or center to surrender custody of the child to the adoptive parent. The release must also authorize the person or entity to whom the child is released "to obtain any medical treatment, including circumcision of a male child, reasonably necessary for the care of the minor and to authorize any physician or medical services provider to furnish additional services deemed reasonable and necessary." A hospital or birthing center acting in accordance with the release will not be held liable because of its act. The hospital or center does not need a court order to surrender custody of the child when it has a properly written release.
Ark. Code Ann. § 9-9-101.

Garrett's Law Adoptions

Arkansas has enacted a law designed to facilitate the adoption process for babies born to mothers who are using illegal substances. Arkansas law considers it "neglect" under the child maltreatment laws for a child to be born with an illegal substance present in its body or fluids. It is also "neglect" for a woman giving birth to have an illegal substance in her body or fluids because of her knowing use of the illegal substance. In such situations, after the child maltreatment report is made, the mother has the option to place the newborn for adoption through a licensed child placement agency or a private adoption with a person licensed to practice medicine or law.
Ark. Code Ann. § 9-9-702, 12-18-103(13)(B), as amended by Act 474 of 2009

Reimbursement of Medical Expenses

While a parent or guardian of a minor cannot receive any kind of compensation for relinquishing a child for adoption, incidental costs for prenatal care, delivery, and postnatal care may be provided. Acceptable compensation includes reasonable housing costs, food, clothing, general maintenance, and medical expenses as long as they represent expenses for services rendered, or reimbursement for incurred expenses, and not payment for the child.
Ark. Code Ann. § 9-9-206, as amended by Act 539 of 2007.

Health History and Genetic and Social History

Before many adoption placements may occur, the person or entity arranging the adoption must provide to the prospective adoptive parents a detailed written health history, and genetic and social history of the child that exclude information that would identify the birth parents or members of the birth parents' family. Identifying information must be kept and filed separately. A genetic and social history includes: (1) a medical history; (2) health status; (3) cause of and age at death of parents; (4) height, weight, eye color, and hair color; (5) when appropriate, levels of educational and professional achievement; (6) ethnic origins, and (7) religion. A health history is a comprehensive report of the child's health status at the time of placement for adoption, and medical history, which includes a neonatal, psychological, physiological, and medical care history. The health history and genetic and social history must be clearly identified as such and must be filed with the court clerk before entry of the adoption decree. Upon court order, the clerk may provide a person identified by the court with a copy of that document.

The histories must be kept by the agency, entity, or person handling the adoption for 99 years. However, if the agent, entity, or person goes out of business during this time, it must transfer these records to the Department of Human Services. A licensed adoption agency may transfer its records to another licensed adoption agency provided it gives notice to the Department of Human Services.

The health and genetic and social histories must be made available on request to (1) adoptive parents of the child or the child's guardian; (2) the adoptee; (3) in the event of the death of the adoptee, the adoptee's children, the adoptee's widow or widower, or the guardian of any child of the adoptee; or (4) the birth parent of the adoptee; (5) any child welfare agency having custody of the adoptee. The person requesting the information is responsible for paying the reasonable costs incurred for providing the information.

It is not necessary to prepare and provide the health, genetic and social history of the child if the person to be adopted is an adult, the prospective adoptive parent is a stepparent or the prospective adoptive parent and the child to be adopted are related to each other within the second degree of consanguinity.

Ark. Code Ann. § 9-9-212, as amended by, Act 539 of 2007 & Act 724 of 2009, Ark. Code Ann. §§ 9-9-501, 505.

Paternity

Upon a motion by either party to determine whether a putative father can be excluded as the biological father or to establish the probability of paternity, a court must order paternity testing, which may include deoxyribonucleic acid (DNA) testing for the putative father, mother, and child. When either the mother or the putative father is deceased or unavailable for testing, and they have a relative who is willing to participate, then the court must include the relative in its order for paternity testing.

The court will appoint a qualified expert to conduct the testing. A written report of the test results, certified by the expert in a signed and sworn affidavit, may be introduced into evidence without calling the expert as a witness unless there is a challenge to the test procedures or results.

A *prima facie* case of paternity is established when test results show a 95% or greater probability that the putative father is the biological father of the child, together with corroborating testimony of the mother concerning the putative father's presence during the probable period of conception. Other prima facie cases of paternity exist when the putative father and mother acknowledge the father's parenthood, the putative father has consented to the appearance of his name on the child's birth certificate, or he has voluntarily registered with the putative father registry. *Ark. Code Ann. §§ 9-10-108, 120.*

Guardianship

"Guardianship for an incapacitated person shall be used only as is necessary to promote and protect the well-being of the person and his property, shall be designed to encourage the development of maximum self-reliance and independence of the person, and shall be ordered only to the extent necessitated by the person's actual mental, physical, and adoptive limitations." *Ark. Code Ann. § 28-65-105.*

Who is Incapacitated

An incapacitated person is one who is "impaired by reason of a disability such as mental illness, mental deficiency, physical illness, chronic use of drugs, or chronic intoxication, to the extent of lacking sufficient understanding or capacity to make or communicate decisions to meet the essential requirements for his or her health or safety or to manage his or her estate." This definition focuses on capacity to make or communicate decisions, that is, whether one can understand and appreciate facts necessary to make an informed decision and can communicate that decision.

The definition of an "incapacitated adult" includes an "impaired adult" as defined under the Adult Maltreatment Custody Act. An "impaired adult" is a person aged 18 years or older, who is in the custody of the Department of Human Services, and who, as a result of mental or physical impairment, is unable to protect himself or herself from abuse, sexual abuse, neglect, or exploitation.

An incapacitated person is also one who is under the age of 18 years and not married, or one who is detained by a foreign power, or who has disappeared. An incapacitated person for whom the court has appointed a guardian is not presumed to be incompetent, and therefore retains all his legal and civil rights except as expressly limited by the court.

A person is not incapacitated for relying consistently on treatment by spiritual means through prayer alone for healing in accordance with his or her religious tradition and is being furnished with such treatment.

Ark. Code Ann. §§ 28-65-101, as amended by Act 121 of 2009, 104, 106. See also Ark. Code Ann. § 9-20-103.

See also, Mental Health - Involuntary Commitment at page 183.

Petition and Hearing

Any person can petition for the appointment of himself or some other qualified person as guardian of an incapacitated person. Before the court will appoint a guardian, however, the alleged incapacitated person, and others as provided by law, are entitled to notice of a hearing at least 20 days before the hearing. The alleged incapacitated person has the right to be represented by counsel, present evidence on his own behalf, cross-examine adverse witnesses, and require the presence of the professionals who prepared the evaluation declaring incapacity.

If the court finds incapacity, then it determines the extent of incapacity and the feasibility of less restrictive alternatives to guardianship. If the court finds that the alleged incapacitated person is substantially without capacity to care for himself or his estate, the court will appoint a guardian for the person, estate or both. The court order will specify the nature of the guardianship and the amount of bond to be given. If the court finds the guardianship should be limited, then the order will set forth the specific powers, authorities and duties of the guardian, and may even list the powers the incapacitated person may exercise on his own. In cases involving minor children, the order may make provisions for visitation and child support as in

other cases involving child custody.
Ark. Code Ann. §§ 28-65-205, 207, 213, 214.

Evaluation

Portions of the state laws on proving incapacity (Ark. Code Ann. § 28-65-211 and § 28-65-212) may be pre-empted by the federal Healthcare Portability and Accountability Act (HIPAA) because those laws do not always mandate that court testimony and evaluations entered in evidence, which involve Protected Health Information (PHI), be pursuant to a court order. ***See HIPAA at page 115.*** Before taking action based on these statutes, legal counsel should be consulted.

Under state law, in determining incapacity for a cause other than minority, disappearance, or detention by a foreign power, the court requires evidence of incapacity by oral testimony or sworn written statement from qualified professionals. If the incapacitated person is in an institution for treatment of a mental or nervous disease or in a hospital or penal institution, one of the professionals must be a member of the medical staff of that hospital or institution.

The evaluation must state (1) the alleged incapacitated person's medical and physical condition; (2) his or her adaptive behavior; (3) his or her intellectual functioning; and (4) recommendations as to the specific areas for which assistance is needed, including the least restrictive alternatives available. If no evaluations performed in the last six months are available, the Court will order one for use at the hearing. This provision in state law likely would not be pre-empted by HIPAA, but legal counsel should be consulted.
Ark. Code Ann. §§ 28-65-211 to 212.

Guardian's Authority

The guardian of the person is responsible for caring for the ward, and if the ward is a minor, making sure he is properly trained and educated. The guardian of the estate is responsible for protecting and preserving the estate, including making prudent investments.

However, the guardian cannot make the following decisions without receiving express court approval: (1) consent to abortion, sterilization, psychosurgery, or removal of bodily organs except when the ward's life is threatened; (2) consent to withholding life-saving treatment; (3) authorize experimental medical procedures; (4) authorize termination of parental rights; (5) prohibit the incapacitated person from voting; (6) prohibit the incapacitated person from obtaining a drivers' license; or (7) consent to a settlement or compromise of any claim by or against the incapacitated person or his estate.
Ark. Code Ann. § 28-65-301-302.

See also, Malpractice - Informed Consent at page 155.

Abandonment of Newborn

Under the "Safe Haven" Act, when a parent voluntarily leaves a child thirty days old or younger with the emergency department of a hospital or with a law enforcement agency, without expressing an intent to return for the child, the agency or hospital must take possession of the child and may do so without a court order. The law enforcement officer or hospital that takes possession of the child must take the child into protective custody for seventy-two hours and tend to the child's physical health and safety.

Upon taking possession of the child, the officer or hospital must immediately notify the Division of Children and Family Services of the Department of Human Services (DCFS), who

must then initiate a dependency petition for the child. The Act requires the DCFS to attempt to determine whether the child is a missing child.

The hospital or law enforcement agency that takes possession of a child under this law is not civilly or criminally liable for any good faith acts or omissions performed as a result.
Ark. Code Ann. § 9-34-201 to 204, as amended by Act 758 of 2009.

ADVERTISING

Physicians may advertise their services as long as the advertisements are not false or misleading. Physicians may publicize themselves through any form of commercial publication, including newspapers, magazines, telephone directories, radio, television, or direct mail. Physicians may publicize (1) their educational background; (2) the basis on which fees are determined, including charges for specific services; (3) available credit or other methods of payment; and (4) any other nondeceptive information.

Because the public easily can be deceived about some medical matters, physicians who advertise should be cautious as to how they present information. For example, the physician should avoid complex medical terms and illustrations, aggressive advertising that creates unjustified medical expectations, patient testimonials as to the physician's skill, and statements relating to the quality of medical services. All of these methods are susceptible to deceiving or misleading the patient.
Ark. Code Ann. §§17-80-111; 17-95-409; AMA Code of Medical Ethics, §5.02.

AMERICANS WITH DISABILITIES ACT

Congress enacted the Americans with Disabilities Act (ADA) to prevent discrimination against persons with disabilities. The ADA governs both employment and service aspects of businesses. In the employment context, the Act applies to businesses with at least 15 employees. The federal Equal Employment Opportunity Commission issues regulations and guidance interpreting the ADA in the employment setting. In the service context, the ADA applies to all "public accommodations," which include hospitals and medical offices. The Arkansas Civil Rights Act of 1993 imposes similar requirements on organizations with nine or more employees.

The ADA and the Rehabilitation Act of 1973 essentially track each other. The Rehabilitation Act, however, applies to those organizations receiving federal funds. Therefore, many health care facilities are subject to both Acts.

In 2008, significant amendments to the ADA were enacted. The amendments, among other things, broadened the definition of "disability" by rejecting the rulings in several decisions by the United States Supreme Court and by rejecting portions of the EEOC's ADA regulations. The new version of the ADA became effective January 1, 2009, and the EEOC is in the process of issuing new regulations and interpretive guidance. The net effect of the 2008 changes is that it has become easier for a person seeking ADA protection to establish that he or she has a disability within the meaning of the ADA. The term "disability" is to be construed in favor of broad coverage to the maximum extent permitted by the amended ADA. Details of all the changes are beyond the scope of this publication. Physicians with specific questions should consult their legal counsel.

Employment

The ADA prohibits employers from discriminating against an individual with a disability, on the basis of disability, in regard to job application procedures; decisions affecting hiring, advancement, or discharge; or in regard to employee compensation, job training, or other terms, conditions, and privileges of employment. The ADA also protects persons who have had a disability in the past or who are regarded as having a disability.

A "qualified individual" is someone who can perform the essential functions of the job he holds or desires to hold, with or without reasonable accommodation for a disability. The employer usually defines the "essential functions of the job" in the job description.

Under the Act, the employer has a duty to make reasonable accommodations for any known actual physical or mental disability, unless the employer would suffer an "undue hardship" in doing so. "Undue hardship" means significant difficulty or expense based on the employer's size, financial resources, etc. Reasonable accommodations could include an employer making existing facilities readily accessible, restructuring job functions, offering modified work schedules, reassigning the disabled person to a more suitable vacant position, buying or modifying job-related equipment, or even providing qualified readers or interpreters for disabled workers. There is no requirement to provide reasonable accommodation for a person who is merely regarded as having a disability.

The Act does not protect employees or applicants who are currently engaging in the illegal use of drugs, whether or not they are currently participating in a drug rehabilitation program. On the other hand, the Act does protect those persons who have been successfully rehabilitated and are no longer engaging in illegal use of drugs, those who are participating in a rehabilitation program and are no longer engaging in such use, and those who are erroneously regarded as engaging in illegal use of drugs.

While alcoholism may be considered a disability, the Act recognizes an employer's right to: (1) prohibit the use of alcohol at the workplace; (2) require all employees to be free of the influence of alcohol at the workplace; and (3) hold an alcoholic employee to the same standards as other employees.

Under the proposed new regulations, infection with the human immunodeficiency virus (HIV) will always constitute a disability for the purposes of employment discrimination under the ADA. However, infection with HIV is not, by itself, considered a significant threat to others in the workplace. An employer with an employee or job applicant who is infected with the HIV virus may use a job qualification standard that an employee "not pose a direct threat to the health or safety of other persons in the workplace." A "direct threat" means the infected person poses a "significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation."

Whether a person poses a direct threat should be determined based on a "reasonable medical judgment that relies on the most current medical knowledge and/or on the best available objective evidence," and not on fear or speculation.

See Acquired Immune Deficiency Syndrome - Physicians with HIV/Hepatitis B/Hepatitis C at page 27.

Generally, employers may not ask about disabilities in the job interview or conduct medical examinations to determine the presence of a disability prior to the employment decision. The employer may ask a potential employee whether she is able to perform essential job functions. Medical examinations may be given after an offer of employment has been made and prior to beginning work so long as all entering employees are subjected to a medical examination. Information obtained from the examination must be maintained on separate forms and in separate medical files and treated as a confidential medical record. This information may be

shared with management personnel who need to know in order to make appropriate work accommodations, safety personnel if the disability might require emergency treatment, and government investigators who are reviewing compliance with the Act.
42 U.S.C. §§ 12101, 12102; 12111-12117, as amended by ADA Amendments Act of 2008, Public Law 110-325 (September 2008) and by the Lilly Ledbetter Fair Pay Act of 2009, Public Law 111-2 (January 2009); 29 Code of Federal Regulations § 1630 and following.

Public Accommodations

The ADA prohibits discrimination on the basis of disability "in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation." *42 U.S.C. § 12182.*

Therefore, barriers existing in architecture or communications must be removed or altered so as not to obstruct access if doing so is "readily achievable." Whether a change is readily achievable may depend on such factors as cost, the type of alteration that would have to be made, the effect on the service provider's budget, the number of employees, and whether the service provider is owned by a larger entity, and if so, its financial resources. Typical alterations include making handicap-accessible entrance doors, rest rooms, elevators, public telephones, parking lots, and adjacent walkways.

Interpreters for Deaf Patients

As part of their responsibilities under the ADA, doctors' offices must provide "auxiliary aids and services" as necessary to achieve "effective communication" with disabled patients. The particular facts of each case determine what service is necessary to effectively communicate with the patient. For example, while an interpreter would be necessary if the communication involved a decision whether to undergo major surgery, an interpreter will probably not be necessary in the case of an ordinary sinus infection, if the patient can read and write or use a computer terminal.

If the patient and physician cannot agree on a method of communication, the decision is left to the physician. But doctors may be liable for a violation of the ADA if the chosen method proves ineffective. While the primary remedy under the ADA is injunctive relief, a civil penalty may be assessed as well, and it is more likely to be assessed if the court finds the doctor to have acted in bad faith. Further, the law "strongly encourages" public accommodations to consult the disabled person in determining what type of service or aid to provide.

Because businesses must bear the cost of providing accommodations to disabled persons, a physician who provides an interpreter may not charge the patient for the expense.

For a referral to a qualified interpreter, physicians may call the Disability Rights Center at (800) 482-1174 or their local state Vocational Rehabilitation Office at (501) 296-1600.
Americans with Disabilities Act of 1990, as amended, 42 U.S.C. §§12101, and following, as amended by ADA Amendments Act of 2008, Public Law 110-325 (September 2008) and by the Lilly Ledbetter Fair Pay Act of 2009, Public Law 111-2 (January 2009).

Telephone Assistance with ADA

The Civil Rights Division of the United States Department of Justice provides free legal guidance on ADA compliance issues. The telephone number is (800) 514-0301 Monday through Wednesday, and Friday from 10:00 a.m. to 6:00 p.m. (EST) or Thursday from 1:00 p.m. to 6:00 p.m. (EST). For computer downloads, call (800) 514-0301. The Web address is www.usdoj.gov/crt/ada or www.ada.gov. *42 U.S.C. §§ 12131 to 12213, as amended by ADA Amendments Act of 2008, Public Law 110-325 (September 2008).*

ANTITRUST LAW

The primary focus of antitrust activity involving physicians is Section 1 of the federal Sherman Anti-Trust Act. This section prohibits joint activities among competitors that restrain trade and decrease competition. To violate this section, there must be (1) concerted activity by two or more entities, and (2) unreasonable restraint of competition.

"Concerted activity" is any formal agreement or informal understanding among two or more persons. As an association of competing physicians, a medical society can satisfy the concerted activity element of the Sherman Act, and thus must be careful to avoid actions that restrain competition. Violation of the law does not require a "formal" organization or understanding. Informal actions by a group of physicians can violate the law. For example, an inference that physicians had engaged in "concerted activity" to fix prices could be made if physicians in separate practices began charging the same fees after they were together at an "informal" meeting, even if that meeting did not generate any written records of any such agreement.

Whether the activity has created an "unreasonable restraint" of competition depends on various factors. Price-fixing by competitors or a group boycott is considered automatically illegal, *i.e.*, *"per se"* illegal. Most other types of activities are judged under a "rule of reason" analysis. This means the courts "balance" the pro-competitive effects against the anti-competitive effects to determine which predominates.

The antitrust laws can be enforced civilly or criminally. The United States Department of Justice can initiate civil and criminal prosecution. The Federal Trade Commission (FTC) can bring civil antitrust cases. On the criminal side, violations are felonies punishable by a fine of up to $10 million in the case of a corporation, and, in the case of an individual, up to three years in prison and/or a maximum fine of $350,000. On the civil side, the government can obtain injunctive relief and triple damages. In some cases, private parties are allowed to bring civil suits as well. State attorneys general also have authority to enforce state antitrust laws. Most physicians' insurance policies will not cover antitrust claims.

Integration: Mergers, IPAs, PHOs, etc.

In antitrust law, "integration" is the key. Complete integration occurs when physicians merge their separate practices into a single business entity. As long as they are truly a unified practice, they can discuss fees or take most any other action without running afoul of antitrust laws because there can be no agreement or conspiracy ("concerted activity") when you have only one entity.

Only partial integration occurs when physicians join forces to form an independent practice association (IPA), physician-hospital organization (PHO), and similar joint ventures. These types of joint ventures are not *per se* illegal but are judged under the "rule of reason". The degree of integration makes all the difference. If the venture is sufficiently integrated, the members can discuss fees and take other concerted actions that would otherwise be prohibited.

To be sufficiently integrated, the venture must be either "financially" or "clinically" integrated. Financial integration usually means substantial risk-sharing among the physicians. Clinical integration is the process by which physicians combine their resources to produce and market their services jointly on the operational side. Indicators of clinical integration include a centralized information system that tracks physician and patient data; development of practice standards and protocols; joint utilization review and quality assurance; remedial action against physicians failing to meet standards; a significant investment of capital by the participating physicians in the joint operations, etc. In either form, financial or clinical, the integration must

have an overall purpose of controlling costs and enhancing the quality of care. Any agreement on fees must be "reasonably necessary" (secondary) to those goals.

If an IPA or other joint venture is not sufficiently integrated, it will have to use a "messenger model," which involves the use of a third-party to relay offers between physicians and managed care plans but which forbids "negotiation." While this is the method sanctioned by the federal agencies, it is cumbersome and of limited utility in actual practice.

In recent years the enforcement agencies have investigated numerous IPAs and similar joint ventures. The FTC was particularly aggressive, shutting down or forcing settlements out of IPAs all across the country, particularly in 2002 and 2003. In most cases, the IPAs claimed to be using the "messenger model," while the FTC alleged they were not and accused the physicians of coming together primarily to gain more market power in order to jointly negotiate fees. The FTC has been particularly skeptical of IPAs whose members make up a large share of the market, for instance, a majority of an area's primary care doctors.

However, in a series of advisory opinions over the last three years, the FTC has found some proposed integration models lawful because the benefits to consumers of integration outweigh the anti-competitive effect that might result from collective rate-setting or collective rate negotiations. Some of the features of these approved models include:

(1) Selective participation of network physicians in order to increase the likelihood that participating networks are fully committed to the goals of the integrated system.
(2) Investment of monetary and human capital by participation on committees and development of protocols that motivate participants to work toward success.
(3) Infrastructure and program capability supporting the integrated model.
(4) Measurement and evaluation of performance results that provide proof that the beneficial results are occurring.
(5) Quality improvement programs that reward member physicians when quality measures are met.

Physicians considering an integration venture should consult with an attorney familiar with healthcare anti-trust law from the outset in order to avoid the pitfalls that might cause a contemplated plan to be out of compliance with the law.

Exceptions

The First Amendment of the United States Constitution provides protection for the rights of physicians and medical societies to take positions and lobby the government on issues affecting the practice of medicine and to advocate particular government action, as long as the advocacy is in good faith.

Additionally, under the principle of state sovereignty, joint conduct by private parties that is clearly authorized and "actively supervised" by the state is permitted. Very few states have attempted to enact such a process with regard to supervision of fee negotiations. A more common example, which is insulated from anti-trust laws, is a state-authorized peer review committee that makes credentialing determinations.

Union actions are not protected from antitrust laws unless the negotiations occur in a true employer-employee setting, which is usually not the case for physicians.

ARKANSAS DEPARTMENT OF HEALTH AND STATE BOARD OF HEALTH

For the time period between mid-2005 and mid-March 2007, the Arkansas Department of Health and the State Board of Health were made part of the Arkansas Department of Human Services,

which was renamed the Arkansas Department of Health and Human Services ("DHHS"). The Department of Health was renamed the Division of Health of DHHS. However, this arrangement only lasted until March 19, 2007, when the entities were split up again and the Arkansas Department of Health regained its former name. Some laws and regulations enacted while the entities were combined still refer to them by their former names.
Ark. Code Ann. § 25-9-101, as amended by Act 384 of 2007.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

After a brief name change between mid-2005 and mid-2007, the Arkansas Department of Human Services ("DHS") has regained its longtime name. In July 2005, it was combined with the Arkansas Department of Health, and renamed the Department of Health and Human Services ("DHHS"), but the two were separated again effective March 19, 2007.. Some laws and regulations enacted while the entities were combined still refer to DHS as DHHS.
Ark. Code Ann. § 25-10-101. as amended by Act 384 of 2007.

ARKANSAS STATE MEDICAL BOARD

Powers and Duties

The Arkansas State Medical Board is authorized to promulgate rules, regulations, and bylaws necessary in regulating physicians; to employ attorneys or request aid from prosecutors; to employ secretarial and administrative assistance necessary in executing board mandates and protecting the people of Arkansas; to employ inspectors; to examine all applicants applying for a license to practice medicine; and to consider and give deference to data, studies, consensus documents, and conclusions issues by the Centers for Disease Control and Prevention or the National Institutes of Health.
Ark. Code Ann. § 17-95-303.

The board also has authority to employ a medical director, who shall hold a valid license to practice medicine in this state, to evaluate medical issues and assist in investigations pending before the board.
Ark. Code Ann. § 17-95-303.

2009-10 Changes.

Changes to Definition of "Unprofessional Conduct"

Under 2009 Arkansas statutory amendments, the definition of "unprofessional conduct" for a physician has been expanded to include "committing an ethical violation as determined" by rules of the Arkansas State Medical Board. The new Regulation 32, effective April 1, 2010, lists specific ethical violations. Regulation 32 classifies as ethical violations the following conduct: (1) engaging in sexual or romantic relationships with patients (now in Regulation 2); (2) breaching the physician-patient privilege; (3) failure to disclose to a patient the physician's ownership interest in an outside facility or service to which the physician refers the patient; (4) sexual harassment of co-workers, employees or patients at a clinic or hospital, and (5) "grossly over-utilizing," ordering or performing tests or procedures when that may result in harm to the patient.
Ark. Code Ann. § 17-95-409(a)(2)(S); Reg. 32.

See Licensing, Physician, Grounds for Denial, Suspension or Revocation at Page 148.

Delegation of Medical Procedures. ***See Delegated Medical Procedures at Page 63 for changes to the relevant statutes.*** The Medical Board has promulgated a regulation dealing with this issue.

Licensing

Under the Medical Practices Act, the board licenses medical doctors, osteopaths, occupational therapists, occupational therapy assistants, respiratory therapists, physician assistants, radiology practitioner assistants and radiologist assistants.

Subpoena Power

The board possesses the power to subpoena physicians to appear before it. The board issues a subpoena to the sheriff who serves the physician by delivering a copy of the subpoena and by tendering fees covering one day's attendance and mileage as allowed by law.

The subpoena may direct the physician to appear with documents under his control and which he is bound by law to produce in evidence. The Arkansas Bar Association's Health Law Section's opinion in 2003 was that this state law provision still was enforceable even in light of the federal Health Insurance Portability and Accountability Act (HIPAA). Since subsequent revisions to HIPAA, the Health Law Section has withdrawn its prior publication on HIPAA and has not taken a position. Practitioners with any questions on this issue should consult legal counsel.

Ark. Code Ann. § 17-80-102.

Failure to Appear

Witnesses receiving a subpoena who fail to appear before the board may be subject to an arrest warrant compelling appearance in circuit court. The circuit court possesses the power to cite the witness for contempt, and the witness remains liable for any damages for nonattendance under Arkansas law.

Ark. Code Ann. § 17-80-102.

Continuing Medical Education Requirements

The Arkansas State Medical Board possesses the power to establish continuing medical education (CME) requirements for licensed practitioners. The board's Regulation 17 requires physicians to earn at least 20 CME credit hours a year. Under certain extenuating circumstances, the physician may get a time extension upon written application and approval by the board. The physician may consult the board's rules and regulations for a list of the eight categories of approved CME activities

When the physician applies for license renewal, (the renewal deadline is the last day of the physician's birth month), the physician certifies, under penalty of perjury, that he or she has met the CME requirements. Physicians must keep their CME records for at least three years from the end of the reporting period, and may be asked to produce them for board inspection.

If a licensed practitioner fails to meet CME requirements; the board may deny renewal of the practitioner's license or may suspend or revoke it. Questions regarding CME requirements may be directed to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, Arkansas, 72202, (501) 296-1802, fax: (501) 296-1806.

Ark. Code Ann. § 17-80-104; Arkansas State Medical Board Regulation 17.

Regulations

To obtain a copy of the Rules and Regulations, send a check or money order for $15 to Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, Arkansas 72202 or call (501) 296-1802, or download for free at www.armedicalboard.org.

The Board promulgated new regulations in 2010 expanding the definition of "unprofessional conduct" to include "ethical violations," based on Act 1178 of 2009, which has been codified at Ark. Code. Ann. § 17-95-409(a)(2)(S). This Regulation 32 is effective April 1, 2010. The Board has proposed a regulation on delegation of medical procedures by a physician to an assistant.

The board rules and regulations include the following topics:

Definition of Malpractice..... Reg. 2, paragraphs 1-6

Minimum Standards for Establishing Physician-Patient Relationship Reg. 2, paragraph 8
Unrestricted Licensure for Graduates of Foreign Medical Schools..... Reg. 3
Licensure and Practice of Occupational Therapists ..... Reg. 6
The Prescribing of Amphetamines..... Reg. 7
Licensure and Practice of Respiratory Care Practitioners ..... Reg. 10
Dispensing Physicians ..... Reg. 12
Reciprocity for Physicians Licensed Out-of-State..... Reg. 13
Licensing Examination ..... Reg. 14
Physicians, HIV, HBV, and HCV..... Reg. 16
Fee Schedule for Centralized Verification Service..... Reg. 18
Pain Management Programs ..... Reg. 19
The Practice of Medicine by Non-Residents ..... Reg. 20
Anorexiant Drug Guidelines..... Reg. 21
Laser Surgery Guidelines..... Reg. 22
Malpractice Reporting Guidelines ..... Reg. 23
Rules Governing Physician Assistants..... Reg. 24
CCVS Advisory Committee Guidelines ..... Reg. 25
Governing Informed Consent for Abortion ..... Reg. 26
Informed Consent for Gastric Bypass Surgery .... Reg. 27
Educational License to Practice Medicine in the State of Arkansas..... Reg. 28
Governing Radiology Assistants/Radiology Practitioner Assistants.. …Reg. 29

Physicians receive a copy of these rules and regulations when they are initially licensed. In August 2008, the Board created Regulation 30: Collaborative Practice, explaining the requirements of a physician who desires to enter into a collaborative practice agreement with an advanced practice nurse. This regulation is not presently in effect, and the implementation date of it has been delayed until further notice of the Board as of October 2008.

Investigations and Inspections

The State Medical Board utilizes the investigators of the Division of Pharmacy Services and Drug Control of the Department of Health to determine whether a violation of law, improper practice of medicine, or a violation of the rules and regulations of the board has occurred. The investigators are authorized to investigate, inspect, and copy records of all licensed practitioners. Records, prescriptions, and orders that have been copied do not become public records merely by use in a disciplinary hearing, nor do patients' or licensed practitioners' property rights in these documents lapse because of such use. The Arkansas Bar Association's Health Law Section's

opinion in 2003 was that this state law provision still was enforceable even in light of the federal Health Insurance Portability and Accountability Act (HIPAA). Since subsequent revisions to HIPAA, the Health Law Section has withdrawn its prior publication on HIPAA and has not taken a position. Practitioners with any questions on this issue should consult legal counsel.
Ark. Code Ann. §17-80-106; 17-95-304..

Warrants and Authorization to Copy

Investigators may copy records, prescriptions, and orders without an administrative "inspection warrant" or search warrant, but they must possess a copy of an authorization from the Director of Pharmacy Services and Drug Control. Inspection warrants are issued by a judge on a showing of a valid public interest sufficient to justify the inspection as described in the application for the warrant. Inspection warrants are necessary when documents will be used in a criminal proceeding.

The physician, however, may refuse to tender copies of the records. The board may then issue a subpoena for the records. If the physician still refuses, the circuit court may cite the physician for contempt if the board so requests.
Ark. Code Ann. § 17-80-106; 17-95-304.

Order and Notice of Hearing

Upon a probable violation of the Medical Practices Act or board regulations, the board shall review the complaint and issue an order and notice of hearing to the license holder. The order and notice must specify the charges in sufficient detail that the accused person has a full and complete disclosure of any alleged acts of misconduct, impropriety, or lack of qualification. A copy of the order and notice of hearing must be sent by registered mail to the person's last address of record along with a written notice of the time and place of the hearing and a statement advising the person of the opportunity to be present in person or by counsel. The hearing may not take place sooner than thirty days from the date of the mailing of the notice.
Ark. Code Ann. § 17-95-410.

See also, Licensing, Physician at page 145.

ARTIFICIAL INSEMINATION

Artificial insemination may only be performed under the supervision of licensed physicians. The mother, the sperm donor, and the husband (if the mother is married) must agree to the artificial insemination by written statement. The physician must certify the signatures and date of insemination.

A married couple having a child by artificial insemination are deemed to be the parents if the husband consents in writing to the artificial insemination. An unmarried woman giving birth by artificial insemination is deemed to be the parent of the child unless the woman is a surrogate mother.

Surrogate Mothers

Surrogate mothers shall be listed as the natural mother on the child's birth certificate. However, a court may order a substituted certificate showing a different mother. The legal mother is the woman who has manifested an intent to act as the mother in raising the child.

A child born by a surrogate mother is the child of (1) the legal mother and the biological

father; (2) the unmarried biological father; or (3) the unmarried woman intended to be the mother if an anonymous donor's sperm was used.
Ark. Code Ann. §§ 9-10-201 and following.

BREAST CANCER ACT

The University of Arkansas for Medical Sciences houses the University of Arkansas Breast Cancer Research Program. The program supports research into the cause, cure, treatment, early detection, and prevention of breast cancer. Research grants are awarded on the basis of research priorities and scientific merit as determined by peer review. The Oversight Committee on Breast Cancer Research, made up of seven members appointed by the governor, governs the peer review process. Grant applications are modeled on those of the National Institutes of Health.

The Act also establishes the Department of Health Breast Cancer Control Program, BreastCare, which provides for early detection, diagnosis, and treatment of breast cancer. Persons participating in the program are given screening exams and medical referrals. Financial assistance is available. To be eligible for BreastCare, the patient must be an Arkansas resident who is 40 years of age or older, uninsured or underinsured, and have an income at or below 200 percent of the Federal Poverty Level.

To participate in providing BreastCare, call the BreastCare Program at the Arkansas Department of Health at (800) 482-5400, ext. 2636 or ext. 2785. To refer a patient or check for the eligibility of a patient, call BreastCare at (877) 670-2273 between the hours of 8 am and 4:30 p.m. For further information about BreastCare, please visit the website at http://www.arbreastcare.com/ or call (877) 670-2273 between the hours of 8 a.m. and 4:30 p.m.
Ark. Code Ann. §§ 20-15-1301 to 1304.

CANCER

See Reporting, Mandatory Physician at page 216.

CHILDREN'S CATASTROPHIC ILLNESS GRANT PROGRAM

The full name of this program is the "Baby Sharon's Children's Catastrophic Illness Grant Trust Fund." Recipients of the grants are chosen by a Program Committee appointed by the governor and others. The Committee must consult with Arkansas Children's Hospital concerning the grant applications. The fund is used exclusively by the Committee for the grant program. The state Department of Finance and Administration dispenses the funds to recipients.

Money for the fund is raised through check-offs on Arkansas individual and corporate income tax returns, and through grants, gifts, and bequests, as well as from any funds appropriated by the state.
Ark. Code Ann. § 26-35-1201 and following, Act 827 of 2007.

CIVIL IMMUNITY

Under state law, physicians and other health care professionals who render medical services voluntarily to patients are immune from civil damages for negligent acts or omissions in certain

situations. The physician must not receive compensation, and the services must be provided at free or low-cost medical clinics that do not accept insurance and that are registered with the State Board of Health. Patients must be informed of the immunity prior to any treatment, and they must sign written acknowledgements of same on a form approved or designated by the Arkansas Health Department. Liability remains for grossly negligent acts or omissions, or for willful misconduct. Under certain circumstances, federal law also provides some immunity from tort liability for ordinary negligence for physicians and others performing volunteer services for non-profit organizations.
Ark. Code Ann. § 16-6-201; 42 U.S.C. § 14501 and following

See also, Emergency Medical Care - Good Samaritan Law at page 81; Tort Liability-Immunity at page 239.

CLIA

Applicability

The Clinical Laboratory Improvement Act of 1988 (CLIA) originally authorized the federal Department of Health and Human Services (DHHS), through the Centers for Medicare and Medicaid Services (CMS), to issue federal standards governing clinical laboratories that test human specimens for the diagnosis, prevention or treatment of disease or the health assessment of patients. CLIA applies to labs seeking payment under Medicare or Medicaid; the requirements are the same for Medicare approval as for CLIA certification. Laboratories that are exempt from CLIA include forensic labs, research labs, and labs certified by the, Substance Abuse and Mental Health Services Administration (SAMHSA) but only for drug testing. Federal laboratories also are subject to CLIA regulations unless the Secretary of HHS has stated otherwise. In Arkansas, the Department of Health regulates and licenses clinical laboratories under CLIA. Physicians who need further information may contact the sources listed below.

Laboratory Licensing:
Arkansas Department of Health
Director of Health Facilities
5800 West 10th Street, Suite 400
Little Rock, AR 72204
(501) 661-2201

For a book entitled, "CLIA 88 and Your Laboratory: A Guide for Physicians and Their Staff," and personal assistance with questions, contact:

American College of Physicians
25 Massachusetts Avenue, NW, Suite 700
Washington, DC 20001-7401
(202) 261-4500 - Customer service: (215) 351-2600 or 1-800-523-1546 ext.2600
Or
American College of Physicians
190 New Independence Mall West
Philadelphia, PA 19106-1572

The primary CLIA regulations are found at 42 Code of Federal Regulations, Part 493 and are contained in volume 42 Code of Federal Regulations, Part 430 to End, which may be ordered from this address:

U.S. Government Printing Office
Superintendent of Documents
P.O. Box 979050
St. Louis, MO 63197-9000
(202) 512-1800 or 1-866-512-1800 - Fax: (202) 512-2104
Email: contactcenter@gpo.gov

The regulations also may be accessed at www.gpoaccess.gov/cfr/index.html.

Compliance with Standards

CLIA has grouped thousands of laboratory tests into one of three categories: waived tests, tests of moderate complexity, or tests of high complexity. Labs performing tests that fall within these categories are required to register with and be certified by CMS. A lab will be "out-of-compliance" unless it (1) has a current, unrevoked or unsuspended certificate of waiver, a registration certificate, certificate of compliance, certificate for provider-performed microscopy (PPM) procedures, or a certificate of accreditation issued by HHS; or (2) is CLIA exempt.

Laboratories Performing Waived Tests

A laboratory may qualify for a certificate of waiver if it limits its testing to those simple tests that (1) are cleared by the FDA for home use; (2) employ methodologies that are so simple and accurate as to render the likelihood of erroneous results negligible; or (3) pose no reasonable risk of harm to the patient if the test is performed incorrectly. Simple tests include:

1. dipstick or tablet reagent urinalysis (non-automated) for the following: bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein, specific gravity, and urobilinogen;
2. fecal occult blood;
3. ovulation tests - visual color comparison tests;
4. urine pregnancy tests - visual color comparison tests;
5. erythrocyte sedimentation rate - non-automated;
6. hemoglobin - copper sulfate - non-automated;
7. blood glucose by glucose monitoring devices cleared by the FDA specifically for home use;
8. spun microhematocrit; and
9. hemoglobin by single analyte instruments with self-contained or component features to perform specimen/reagent interaction, providing direct measurement and readout.

To qualify for a certificate of waiver, the lab must follow manufacturers' instructions for performing the test, have an approved application with HHS, and have paid the appropriate registration fee. A certificate of waiver is valid for two years. Laboratories falling within this lowest level of scrutiny are subject to unannounced inspections by HHS. If the lab is performing even one moderate to complex test, then it must register and seek certification in that higher category.

A lab that fails to comply with these CLIA requirements will not only have its certificate of waiver suspended or revoked, but also will be denied Medicare or Medicaid payments. Labs are

entitled to notice and a hearing, and may appeal the finding to an administrative law judge.

To renew an application, the lab must complete a renewal application not less than nine months, nor more than one year, before the expiration of the certificate.

Laboratories Performing Moderately or Highly Complex Tests

In addition to announced or unannounced inspections, labs falling within these more complex categories are subject to more regulations and higher standards. Set forth below is a list of areas CLIA covers.

1. Employee personnel standards. In the moderate category, the standards cover testing personnel, technical consultants, clinical consultants, and the lab director. *42 Code of Federal Regulations § 493.1403 and following (especially §493.1409, §493.1415, & §493.1421).* In the high complexity category, the regulations also cover testing personnel and general supervisors as well as cytology general supervisors and cytotechnologists. *42 Code of Federal Regulations § 493.1441 and following (especially §493.1447, §493.1453, §493.1459, §493.1467, §493.1481, & §493.1487).*
2. Proficiency testing. Labs will be subjected to proficiency testing in which they receive a number of specimens from the monitoring lab. These samples must be examined or tested with the laboratory's regular patient workload by personnel who routinely perform the testing, using routine laboratory methods. *42 Code of Federal Regulations § 493.801.*
3. Facility Administration. CLIA-approved labs must be constructed, arranged and maintained to ensure space, ventilation, and utilities necessary for conducting all phases of the testing process. A laboratory must have appropriate and sufficient equipment, instruments, reagents, materials and supplies for the type and volume of testing that it performs. Laboratories must establish safety procedures and maintain records, slides, blocks, and tissues for the required period of time. . *42 Code of Federal Regulations § 493.1101- 493.11054.*Quality assessment. The quality assessment program must evaluate the effectiveness of a laboratory's policies and procedures, identify and correct problems, assure the accurate, reliable and prompt reporting of test results, and assure the adequacy, competency, and experience of the staff. *42 Code of Federal Regulations § 493.1200 and following (especially §493.1239).*

Enforcement Measures

HHS may impose various sanctions on laboratories that fail to comply with CLIA regulations. There are three principal sanctions: suspension, limitation, or revocation of any type of CLIA certificate. Alternatively, CMS may impose a directed plan of correction, state on-site monitoring, civil monetary penalty, civil suit to enjoin the activity that CMS believes would constitute a significant hazard to the public health, or imprisonment and fines. In addition, the Secretary of HHS also will publish annually a list of all laboratories that have been sanctioned during the preceding year. Finally, the laboratory may be excluded from participating in the Medicare and Medicaid programs.

42 Code of Federal Regulations §§ 493.1800 and following,

CLONING

It is unlawful for any person or entity, public or private, to perform or attempt to perform human cloning. Under state law, human cloning means human asexual reproduction,

accomplished by introducing the genetic material from one or more human somatic cells into a fertilized or unfertilized oocyte whose nuclear material has been removed or inactivated so as to produce a living organism, at any stage of development, that is genetically virtually identical to an existing or previously existing human organism. It is also unlawful to ship, transfer, or receive for any purpose an embryo, fetus, human oocyte, or human somatic cell produced by human cloning or for the purpose of human cloning. In addition to criminal penalties, any person or entity violating this law may be fined not less than two hundred and fifty thousand dollars ($250,000) or twice the amount of any pecuniary gain that is received by the person or entity, whichever is greater.
Ark. Code Ann. § 20-16-1001 and following.

COLLECTIONS, DEBT

Bankruptcy

Patients who file bankruptcy usually seek to either discharge their debts entirely (a Chapter 7 bankruptcy case) or pay all or a portion of their debts with their disposable income over time (a Chapter 13 bankruptcy case). When the physician's office receives notice from the bankruptcy clerk or otherwise becomes aware that the patient has filed bankruptcy, all collection efforts for past services must stop. Confirmation that a patient has filed for bankruptcy in Arkansas may be obtained by calling the clerk of the United States Bankruptcy Court or by checking on www.arb.uscourts.gov.

A person filing for bankruptcy should list all his creditors, and those creditors will then receive notice from the Bankruptcy Court. The creditors will be given a deadline to file a "proof of claim" with the Bankruptcy Court. A "proof of claim" is an official bankruptcy form that has blanks for the amount of the claim, the services rendered, who to pay, whether the claim is secured or unsecured, and instructions for attaching supporting documentation. The proof of claim must be filed before the deadline expires.

Usually the physician's claim will be unsecured. However, the physician may have a secured claim if the physician has a lien, such as where the patient has sued someone for the patient's injuries. **(See Lien Laws, this section.)** The physician's office may want to contact legal counsel if the claim is substantial or there may be a lien involved.

In a Chapter 7 case, most of the patient's property is liquidated, and the money is used to pay creditors in the order of preference set out in the U.S. Bankruptcy Code. If in a Chapter 7 case, once the court discharges the patient's debts, collection efforts may not be renewed. In a Chapter 13 case, the patient will submit a plan to pay all or part of his debts. If the plan is approved by the court and carried out, the patient will receive a discharge, and collection efforts may not be renewed. If either a Chapter 7 or Chapter 13 bankruptcy is dismissed and the patient is not discharged from his debts, collection efforts may be renewed at that time.

Collecting on Bad Checks

Civil Prosecution

Persons who have issued worthless checks have 15 days from the date of written demand to pay the amount of the check, up to $25 in collection fees and any bank fees charged to the holder of the check because the check was dishonored. If the debtor fails to make this payment, and the business subsequently mails a written demand by certified mail, return receipt requested, then the debtor has an additional 30 days to make restitution. Failing to make restitution entitles the business to sue civilly for twice the amount of the check or for an amount not less than $50.00,

whichever is greater; a collection fee up to $25, bank fees charged because the check was dishonored, certain other fees, court costs and attorney fees.
Ark. Code Ann. § 4-60-103.

Criminal Prosecution

The Arkansas "Hot Check Law" allows businesses to initiate criminal charges against persons who have paid for services or goods with a worthless check. Before suit may be brought, however, the business must give the debtor notice by certified or registered mail evidenced by return receipt or by regular mail supported by an affidavit of mailing, that payment was refused for lack of funds. The debtor must be given ten days from receipt of notice to tender payment of the check amount, plus a service charge, which may not exceed $25 per check, and the amount of fees charged by any financial institution because the check was dishonored. The notice must state the total amount due. The notice must also include a statement that failure to remit the amount due in the specified time period may result in turning over the account to the prosecuting attorney for criminal prosecution.

The fines and terms of imprisonment for writing hot checks vary depending on the monetary amount involved and whether it is a person's first, second or third or subsequent offense. In addition to criminal penalties, the debtor may be ordered to make full restitution to the business as well as pay court costs.
Ark. Code Ann. §§ 5-37-303, 305, as amended by Act 632 of 2007 and Act 748 of 2009; 5-4-201, as amended by Act 209 of 2009; 5-4-401.

Debts in Divorce

Arkansas statutory law does not address directly the division of marital debts in a divorce. However, case law provides that the judge in the divorce proceeding has the authority to divide debts between the partners. This does not mean that a patient is not responsible for his medical bills when the divorce decree orders the ex-spouse to pay the medical bills. Since the patient is the party to the contract for services with the physician, the patient is ultimately responsible for paying the medical bills. The physician may, as a matter of courtesy, bill the ex-spouse, but if the ex-spouse refuses to pay the bill, then the patient is responsible for payment.

Deceased Patients' Debts

If an estate has been opened for a deceased patient, a claim for a debt to a health care provider must be filed within a specified time after the estate publishes a notice to file claims in a local newspaper. This notice is aimed at alerting creditors who may be unknown to the estate administrator. Creditors who are known to the estate should receive a written notice to file claims.

All claims against the decedent's estate are classified into one of four categories. If the estate's assets are insufficient to pay all claims, then the personal representative of the estate will make payment first on the costs of estate administration, then to a second category including reasonable funeral expenses and reasonable medical expenses from the decedent's last illness, next, to state tax debt, and lastly to all other claims allowed by the probate division of circuit court. If there are not enough assets to pay all claims within a category, then the assets will be apportioned among the claims in that category.

Claims against the estate must be in a certain form before the personal representative can make payment. They must be in writing and describe the nature and the amount of the claim. If the claim is based on a written document, the document must be attached. Also, the claimant must attach an affidavit stating that the amount is justly due, that no payments have been made

on the claim which are not credited, and that there are no offsets to the claim to the knowledge of the claimant.

The claimant may either file the claim directly with the personal representative or alternatively, and preferably, with the probate division of circuit court. If a claim filed with the personal representative is disapproved or not acted on, the claimant must file the claim with the court within six months after the date of the first publication of notice to creditors, or within 30 days after the date of its presentation to the personal representative, whichever is later. Otherwise, the claimant will be barred from collection.

Claims, to be paid, must be approved by the probate division of circuit court. Once the court has allowed the claim, it will bear interest at the legal rate unless the claim provides otherwise.

Sometimes, the successors to the decedent refuse to, or fail to, open an estate. Because a claimant's opportunity to collect from the estate expires after five years from the decedent's death, the claimant, as an interested party, can petition the court to open an estate.

Ark. Code Ann. §§ 28-1-102(11); 28-50-101, as amended by Act 231 of 2007 and Act 217 of 2009, 103 to 106, 113; 28-48-101.

Fair Debt Collection Practices Act

In response to abusive, deceptive, and unfair debt collection practices by many debt collectors, Congress enacted the Fair Debt Collection Practices Act in 1977. The Act governs the business practices of debt collectors and not mere creditors of consumers. This means that the Act usually does not cover physicians' offices that perform in-house collection activities on their own accounts. However, when collecting a debt if a physician uses any name other than his own which would indicate or suggest that a third person is collecting or attempting to collect such debt, then the physician will be covered by the Act. Also, if the physician's office contracts with an attorney or a debt collection agency, then the provisions of the Act apply to the attorney or agency.

The Act prohibits debt collectors from engaging in conduct that tends to harass, oppress, or abuse debtors; from using false, deceptive, or misleading representations; or from engaging in unfair or unconscionable practices in their debt collection activities. Thus, among other things, a debt collector must not threaten actions that it does not intend to pursue; call before 8 a.m. or after 9 p.m.; call the debtor at work if the collector knows the employer objects; contact the debtor once the debtor has demanded in writing that the collector stop, except to give notice of lawsuit; contact the debtor by postcard; pose as a lawyer or government official; call the debtor without identifying himself; or publicize the debtor's debt other than to the credit bureau. A debt collector who intentionally violates the provisions of this Act is liable to the injured person in an amount equal to the sum of any actual damage sustained by the person, additional damages as the court may allow, and reasonable attorney's fees and court costs.

15 U.S.C. § 1692a-m.

The Federal Act provides that if any state adopts a law that is "substantially similar" to the federal law then the state may be exempted from parts of the federal law. Recently, Arkansas passed the Arkansas Fair Debt Collection Practices Act. The Arkansas Act is almost identical to the Federal Act. Any state can apply to the Federal Trade Commission for a determination of whether the state, as a result of the passage of a substantially similar state law, has become exempt from all or part of the federal law. As of November 2009, the Federal Trade Commission had not published any opinion on whether Arkansas is exempted from any part of the federal law as a result of its passage of the Arkansas Act.

15 U.S.C. §1692o; 16 Code of Federal Regulations §901 and following ; Act 1455 of 2006, codified at Ark. Code Ann. §17-24-501 to 512.

Interest Charges

Physicians are encouraged to avoid harsh or commercial collection practices. However, interest charges may be assessed on delinquent accounts as long as the patient is notified in advance. Notice may be given by posting the billing and collection policy in the physician's waiting room, by distributing leaflets describing the office billing practices, or by a notation on the billing statements. Physicians choosing to assess interest charges should be aware of, and compassionate to, patients with financial and medical hardships.
AMA Code of Medical Ethics, § 6.08.

In Arkansas, the rate of interest is 6% per annum, unless by agreement the contract stipulates otherwise. However, in no event may the maximum rate of interest exceed 5% per annum above the Federal Reserve Discount Rate at the time of contracting.
Ark. Constitution, art. 19 § 13.

Lien Laws

The Medical, Nursing, Hospital and Ambulance Service Lien Act provides that physicians, dentists, certain other practitioners, hospitals, nurses and ambulance services may obtain a lien for the value of services rendered to a patient for an injury suffered through the fault or negligence of another person, on any claim, right of action, and money to which the patient is entitled because of that injury. The lien may also cover attorney fees incurred in enforcing the lien.
Ark. Code Ann. §§ 18-46-101 to 117.

Notice Required

The medical care provider must serve the patient a written notice of claim of lien (known as "service of notice"), and at the same time, serve a copy of that notice on the wrongdoer or on the insurer of the wrongdoer. The provider must also file a copy of the claim of lien, along with an affidavit attesting to service of notice to the patient and wrongdoer, with the clerk of the circuit court in the county where the medical services were provided. The statute sets out in detail what must be included in the notice of claim and how such notices must be served.

Alternatively, if the patient has filed an action in any court, then the medical care provider may, in lieu of or in addition to the above, file in the court where the action is pending a notice of the claim of lien that has been authenticated under oath. This notice of the claim will serve as notice to all parties to the action.

If medical care was not completed at the time of the original filing of notice, then the medical provider must, within 60 days of completion of medical care, deliver a supplementary notice showing the amount claimed under the lien to each person previously notified, and shall file the notice with the court. Supplementary or amendatory notices may be delivered at any time within the period of the statute of limitations by following the same procedures.

Expiration of Liens

The lien will expire if no action is taken to enforce it within certain time limits set out in the statute.

Enforcement of Liens

If a lien has been properly filed and served within the applicable time limits and is considered "perfected", it may be enforced by bringing a court action, as long as the enforcement action is

begun prior to the expiration of any statute of limitations on the debt itself. Other requirements for the court action are explained in the statute.

Assignment of Liens Permitted

A medical provider may assign all liens or claims of liens. The assignee will have full power to enforce the lien or claim of lien.

Written Release Required

When a lien has been satisfied or waived, the medical care provider shall, within five days after a written demand is made by the patient, wrongdoer, or insurer, give a written statement (release) that has been acknowledged before a justice of the peace or notary public.
Ark. Code Ann. §§ 18-46-104 to 105, 108, 114.

The Collection Suit Statute of Limitations

Medical service providers, including physicians, may bring suit to recover charges for medical services any time within two years of the date the services were performed or from the date of the most recent partial payment for the services, whichever is later. The two-year statute of limitations applies only to bringing suit in court. The physician may continue to pursue collection directly from the patient beyond two years.
Ark. Code Ann. § 16-56-106.

See Insurance - HMO - Prohibition Against Balance Billing at page 143.

COLORECTAL CANCER ACT OF 2009

The Colorectal Cancer Prevention, Early Detection, and Treatment Act of 2009 supports research and cancer control activities across Arkansas. Implementation is dependent on funds by appropriated by the General Assembly. Part of the Act would establish a program to provide screenings for low-income or high-risk persons. This program also would carry out activities to improve the education, training, and skills of health professionals in the detection and control of colorectal cancer. For more information, contact the Winthrop P. Rockefeller Cancer Institute Cancer Control and Outreach Department at (501) 526-7045 or (800) 259-8794 between the hours of 8:00 a.m. and 4:30 p.m. or email the Department at cancercontrol@uams.edu .
Act 1374 of 2009, codified at Ark. Code Ann. §20-15-1901 and following, repealing Ark. Code Ann. §20-15-1701.

COMMUNICABLE DISEASES

Duty to Report

Physicians must report cases of certain communicable diseases to the Division of Health Maintenance of the Arkansas Department of Health within 24 hours of discovery. However some diseases that could indicate bioterrorism must be reported "immediately." Reportable diseases are divided into four categories: A, B, C, and D, discussed below.

Those who make and receive any report of a communicable disease must maintain

confidentiality; however, the prosecuting attorney may subpoena reports to investigate or prosecute the offense of exposing another person to the human immunodeficiency virus.
Ark. Code Ann. § 20-15-904; Arkansas State Board of Health's Rules and Regulations Pertaining to Communicable Disease (Rev. August 1, 2005).

Report Contents

Each report should contain the following information: (1) name, location, and telephone number of the reporting physician; (2) name and date of onset of the disease; (3) the name, sex, age, race, address, and telephone number of the patient; (4) the attending physician's name, location, and telephone number; (5) any treatment information; (6) any pertinent laboratory or other information used in the diagnosis.

Additional disease-specific information may be requested. A physician desiring to further discuss reportable diseases may call the Division of Epidemiology at (501) 661-2893 during business hours or (800) 554-5738 after hours, holidays and weekends.

Immediately Reportable Diseases

The following Category A diseases or conditions, <u>whether suspected or confirmed</u>, must be reported immediately to the Arkansas Department of Health because they "are of special importance or may indicate a bioterrorism event." The diseases/conditions are: Anthrax, Botulism (including infant botulism); Hepatitis, Type A; Meningococcal Infections, Pertussis (Whooping Cough), Plague, Q Fever, SARS, Tularemia, Typhus, Variola (Smallpox), Viral Hemorrhagic Fevers, and Chemical Poisoning, all types, including chemical agents of terrorism.

Any unusual diseases or outbreaks also must be reported immediately. These Category C diseases include any unusual diseases or outbreaks that may require public health assistance, but no specific diseases or outbreaks are listed.

<u>Phone Numbers for Immediate Report</u>. To make an immediate report, in Pulaski County, physicians should call (501) 661-2893, if they need to make a report between the hours of 8:00 a.m. and 4:30 p.m. Otherwise the report should be made to (800) 554-5738, which is available 24-hours a day.

Diseases to be Reported within 24 Hours

Other diseases must be reported within 24 hours of diagnosis. Those diseases from Category A diseases are AIDS, Blastomycosis, Brucellosis, CD4+T-Lymphocyte Count, Campylobacteriosis, Chancroid, Chlamydial infections, Cholera, Congenital Rubella Syndrome, Congenital Syphilis, Creutzfeld-Jakob Disease, Cryptosporidiosis, Cyclosporiasis, Diptheria, Erlichiosis, Encephalitis (all types), Enterotoxigenic E. coli, Food poisoning (all types), Giardiasis, Gonorrhea, Haemophilus influenzae Invasive Disease, Hantavirus Pulmonary Syndrome, Hemolytic-Uremic Syndrome, Hepatitis (Type B, C, non-A-non B, or unspecified), Histoplasmosis, H.I.V. (Human Immunodeficiency Virus), Influenza (indicate viral type if known), Kawasaki Disease, Legionellosis, Leprosy, Listeriosis, Lyme Disease, Malaria, Measles (Rubeola), Meningitis (all types), Mumps, Poliomyelitis, Psittacosis, Q Fever, Rabies, (animal and human), Rheumatic Fever, Rocky Mountain Spotted Fever, Rubella, Salmonellosis (including Typhoid), Shigellosis, Streptococcal Disease (invasive group A), Strep. Pneumoniae, Invasive (drug resistant or not resistant), Syphilis, Tetanus, Toxic Shock Syndrome, Toxoplasmosis, Tuberculosis, Vancomycin-resistant enterococci, Varicella (Chickenpox – deaths only), West Nile Virus, and Yellow Fever.

For any pregnant woman infected with AIDS, HIV or Syphilis, the physician's report also must include the trimester of pregnancy.

Category B diseases are reportable occupational diseases and other conditions, including Asbestosis, blood lead levels of over 10 ug/dl for patients 14 years old or younger and levels over 25 ug/dl for patients 15 years old and older, Byssinosis, pesticide poisoning, Pneumoconiosis (coal workers), Mesothelioma, and Silicosis.
Phone Number for Reporting Within 24 Hours. The report may be made on the telephone answering service at (800) 482-8888.

Bacterial Isolates

Category D diseases are bacteria isolates, which upon request must be submitted to the Arkansas Health Department lab for identification/fingerprinting, along with the results of any Pulsed Field Gel Electrophoresis tests. Category D diseases include Neisseria Meningitidis, Salmonella sp., Campylobacter sp., Enterotoxigenic E. coli, Haemophilus influenzae (invasive), Listeria sp., Shigella sp., Staph. aureus (Vancomycin resistant or intermediate susceptible) and Mycobacterium tuberculosis complex.

New Reporting Requirements on Tuberculosis

A 2009 change in the Health Department rules imposes additional informational reporting requirements for tuberculosis. Every physician or health care worker must report the following information concerning tuberculosis to the health department:

(a) Acid fast bacilli in smear or M. tuberculosis in culture

(b) Other significant evidence, pending bacteriological proof

(1) Chest X-ray shadows suggestive of tuberculosis (apical infiltrate, cavity etc.)

(2) Extra-pulmonary tuberculosis (meningeal, bone, kidney, other)

(3) Primary pulmonary tuberculosis cases showing parenchymal infiltrations or hilar node enlargement or pleural effusion.

Ophthalmia Neonatorum

Gonorrheal ophthalmia must be reported to the State Department of Health, Division of Epidemiology, as soon as the disease is suspected.

To prevent infant blindness and the spread of the disease, the attending physician has a duty to administer effective treatment against gonococcal ophthalmia and chlamydial conjunctivitis within one hour of birth. Should a midwife attending the delivery suspect these infections, the midwife must refer the patient to a licensed physician for treatment.

It is the duty of the local health authority in whose jurisdiction the case occurred to investigate suspected cases, confirm the diagnosis by bacteriological examination, and to determine whether appropriate treatment was provided.

Due to the nature of the infection and its communicability, and inasmuch as gonococcal ophthalmia can be treated with penicillin, it is the duty of every physician to administer adequate penicillin therapy at once.

Ark. State Bd. of Health Rules and Regulations Pertaining to Communicable Disease Control, Section, XXI (B) (*Rev. August 1, 2005); Ark. State Bd. of Health Rules Pertaining to the Control of Communicable Diseases – Tuberculosis 2009.*

Other Obligations of the Physician

Isolation

An attending physician, immediately upon discovering a disease requiring isolation of the patient, shall cause the patient to be isolated pending official action by the Director of the state

Department of Health. The physician also must advise members of the patient's household of all measures to be taken to stop spread of the disease. The physician must also furnish the patient's attendants with detailed instructions for disinfection and disposal of infective secretions and excretions, as may be prescribed by the Health Department. Also, any medical provider who has knowledge that an emergency response employee has been exposed to a communicable disease must notify the Health Department immediately. Also any medical provider who knows that a patient with a communicable disease is being transported, transferred, or treated by an emergency response employee must inform the employee of the disease prior to the transport, transfer or treatment.
Ark. Bd. of Health Rules and Regulations Pertaining to Communicable Disease Control, Sections IX, XIII (B & C) (*Rev. August 1, 2005).*

Creutzfeldt-Jacob Disease (CJD)

Any physician or other person who has reason to believe that a deceased person may have been infected by Creutzfeldt-Jacob Disease shall immediately after death attach to the big toe of the right foot a red tag indicator furnished by the Department of Health, or if not available, a tag measuring no less than three inches by five inches, which clearly states the patient may have been infected with Creutzfeldt-Jacob Disease. If the body is wrapped in a covering material and the tag is not visible, a duplicate clearly visible tag must be applied to the outside of the covering. *Ark. Bd. of Health Rules and Regulations Pertaining to Communicable Disease Control, Section XII* (*Rev. August 1, 2005).*

***See also, AIDS at page 24; Identification of Deceased Infected by a Communicable Disease at page 247; Rabies at page 215; Reporting, Mandatory Physician - Reye's Syndrome at page 226; Sexually Transmitted Diseases at page 231; Tuberculosis at* page 241.**

CORONERS, DUTIES OF

The duties of Arkansas coroners are discussed in several locations throughout this *Guide*. ***(See also, Death, Dying, and Disposition of the Dead - Death of a Long-term care Resident at page 62; Death, Dying, and Disposition of the Dead - Death of Hospice Resident at page 62; Medical Records - Subpoena by a Coroner at page 178; Organ Donation at page 193; Reporting, Mandatory Physician at page 216; Vital Statistics at page 242.)*** The Arkansas Association of Counties publishes the *Arkansas Coroner's Procedures Manual,* which details the duties of local coroners. Coroners can obtain a copy of the manual by writing the Association at 1415 West Third Street, Little Rock, AR 72201 or by calling (501) 372-7550. It is also available at www.arcounties.org.

CORPORATE PRACTICE OF MEDICINE

It is not legal for a non-physician-owned corporation to employ licensed physicians to practice medicine for profit. The reason behind this rule is the fear that laypersons, who are not bound by the physician's ethical code, would place the corporation's financial position above good patient care.

Physicians may, however, join with other physicians in forming a medical corporation. The corporate practice of medicine is legal as long as the owners, officers, directors, and shareholders are all licensed physicians.

Health maintenance organizations (HMOs) are statutorily exempt from the corporate practice of medicine law.

Attorney General's Opinion No. 94-204 (citing Ark. Code Ann. §§ 4-29-301 to 311; §§ 23-75-101 to 122; §§ 23-76-101 to 131).

Physicians may choose to organize their practice in the form of a limited liability company. The advantages offered by a limited liability company over a partnership or corporation include limited personal liability, and taxation as a partnership. Physicians organizing as a limited liability company still must obtain a certificate of registration from the Arkansas State Medical Board and comply with the statutes of the Medical Corporation Act.

Ark. Code Ann. §§ 4-29-301 to 312; 4-32-201; 4-32-1401.

CREDENTIALING ORGANIZATIONS

The Arkansas General Assembly has established a centralized credentials verification system operated through the Arkansas State Medical Board. All "credentialing organizations" (hospitals, insurers, HMOs and other managed care organizations) are required to go through the Medical Board's Centralized Credentials Verification System (CCVS), which is certified as a credentials verification organization by the National Committee for Quality Assurance (NCQA) and which complies with the principles for credentials verification organizations set out by the Joint Commission (formerly called the Joint Commission on the Accreditation of Health Care Organizations (JCAHO)). The system replaces the old process by which each separate credentialing organization sought credentialing information from physicians. The board charges physicians an amount not to exceed $100 per year, and may also charge credentialing organizations a fee. The credentialing organizations may not seek information from physicians if that information is available through the board and the board's system meets NCQA and Joint Commission standards. However, credentialing organizations are not prevented from collecting or inquiring about any data not available through the board. Nor are credentialing organizations prevented from reporting to or inquiring of the National Practitioner Data Bank. If a physician refuses to submit information to the board, his or her license may be suspended.

Recredentialing a physician generally must be completed within 30 business days.

The "evaluation and discussion" of credentialing information by a credentialing organization is shielded from disclosure under the Arkansas Freedom of Information Act and is not subject to legal discovery or admission into evidence in any civil proceeding. The credentialing information itself has only limited protection from disclosure.

The Arkansas State Medical Board has promulgated policies and procedures for the CCVS. These policies are available at www.armedicalboard.org or may be obtained by emailing CCVS at ccvs@armedicalboard.org.

Ark. Code Ann. § 17-95-107.

CRIMES AGAINST PHYSICIANS

A person commits a second degree battery if he knowingly, without legal justification, causes

physical injury to a person he knows is a physician, or to a person he knows is any other health care provider, while the physician or provider is performing medical treatment, emergency medical services, or is "in the course of other employment relating to his or her medical training." The law specifically covers all health care providers, licensed or certified health care professionals, and emergency medical services personnel. Second degree battery is a Class D felony, which is punishable by a fine of up to $10,000, imprisonment of up to 6 years, or both.
Ark. Code Ann. § 5-13-202, as amended by Act 827 of 2007, Acts 344 and 689 of 2009; Ark. Code Ann. §5-4-201, as amended by Act 209 of 2009; Ark. Code Ann. §5-4-401.

DEATH, DYING, AND DISPOSITION OF THE DEAD

Definitions

Death is defined by law as the "(1) irreversible cessation of circulatory and respiratory functions; or (2) irreversible cessation of all functions of the entire brain, including the brain stem."

The legal definition of a *terminal condition* is "an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time."

Permanently unconscious means "a lasting condition, indefinitely without change in which thought, feeling, sensations and awareness of self and environment are absent."

Life-sustaining treatment means "any medical procedure or intervention" that, when administered to a patient 18 years of age or older who is permanently unconscious or in a terminal condition, "will serve only to prolong the process of dying or to maintain the patient in a state of permanent unconsciousness."

Ark. Code Ann. §§ 20-17-101, 201.

Rights of Final Disposition

Persons of sound mind and 18 years of age or more may execute at any time a declaration governing the disposition of their bodily remains at death, providing that the declaration comports with laws for disposing of human remains. The declaration must be in writing and signed by the declarant or signed by another person at the declarant's direction, and witnessed by two individuals. The person having possession or control of the declarant's remains may not knowingly dispose of the body in a manner inconsistent with the declaration. If a decedent did not execute such a declaration, the person having lawful possession, charge or control of the remains may dispose of the remains in any manner consistent with the law.

Ark. Code Ann. § 20-17-102, as amended by Act 839 of 2007 and Act 402 of 2009.

Consent for Postmortem (Autopsy)

A person may give consent for his or her own postmortem examination in a signed and acknowledged writing. Whoever of the following persons having custody of the body for burial may also consent to a postmortem examination: father, mother, husband, wife, child, guardian, next of kin, or, if any of the foregoing are not available, a friend or a person charged by law with the responsibility for burial. If two or more persons have custody of the body, then the consent of one is sufficient to make a decision about a postmortem examination.

Ark. Code Ann. § 20-17-302.

Abuse of a Corpse

It is a Class D felony to abuse a corpse. One is guilty of abuse when he knowingly and without legal authorization "disinters, removes, dissects, or mutilates a corpse," or otherwise "mistreats a corpse in a manner offensive to a person of reasonable sensibilities."

Ark. Code Ann. § 5-60-101.

Patient's Self-Determination Act of 1990

This federal law requires health care institutions receiving funds from Medicare or Medicaid

to inform patients about their rights to execute advance directives (living wills) and to control their own health care under state law.
42 U.S.C. §§ 1395cc(f), as amended by Public Law 110-275 of 2008; 1396a(w), as amended by Public Laws 110-275, 110-252, 111-3, and 111-5).

Arkansas Rights of the Terminally Ill or Permanently Unconscious Act

The suggested form of the declaration (advance directive) to be made by a person regarding his medical treatment in certain circumstances includes specific directives on whether nutrition or hydration may be withheld. A physician or other health care provider who is furnished a copy of the directive must make it a part of the patient's medical record and if unwilling to comply with the directive, promptly advise the declarant of the unwillingness.
Ark. Code Ann. § 20-17-202.

Even if a declaration includes a directive to withhold nutrition or hydration, or both, if the terminally ill patient requests nutrition or hydration, it will be provided. However, unless an artificial means is specifically requested, a patient's request for nutrition and/or hydration shall not be honored by use of artificial means, if doing so would require insertion of any apparatus into the patient's body.
Ark. Code. Ann. § 20-17-214.

Advance directives on nutrition and hydration apply only to the declarations made on and after July 16, 2003, which was the effective date of certain changes in the law. All declarations executed before that date remain in full effect, and the provisions of the 2003 law on nutrition and hydration directives "shall not be applied in the interpretation or construction" of any declaration preceding that date.
Ark. Code. Ann. § 20-17-202(g).

Who May Make a Declaration

A person of sound mind and 18 years of age or more may execute a declaration governing the withholding or withdrawal of life-sustaining treatment in the event the person is terminally ill or permanently unconscious. The declaration must be signed by the declarant (or another person at the declarant's direction) and also witnessed by two individuals. If the declarant is pregnant at the time the declaration becomes "operative," the attending physician must not carry out the declarant's wishes if "it is possible that the fetus could develop to the point of live birth with continued application of life-sustaining treatment."
Ark. Code. Ann. §§ 20-17-202(a), 206(c).

Forms for advance directives may be obtained from:

University of Arkansas for Medical Sciences
Division of Medical Humanities
4301 W. Markham, Slot 646
Little Rock, AR 72205
(501) 661-7970
http://aging.uams.edu/upload/docs/Patients/advance_medical_directives.pdf or
http://www.caringinfo.org/UserFiles/File/Arkansas.pdf

Who May Make a Written Request for Another Person

Sometimes, other persons have the right to make a declaration on the behalf of a terminally ill or permanently unconscious person when the person is unable to do so. If the person "is a minor, or an adult where a valid declaration does not exist and a health care proxy has not been [otherwise] designated and who, in the opinion of the attending physician, is no longer able to make health care decisions," then the declaration may be made by "the first of the following individuals or category of individuals who exist and are reasonably available for consultation:"

1. the patient's legal guardian;
2. the parents of an unmarried patient under the age of 18 years;
3. the patient's spouse;
4. the patient's adult child, or if more than one, then a majority of the children who participate in the decision;
5. the parents of a patient over the age of 18 years;
6. the patient's adult sibling, or if there is more than one, then a majority of the siblings participating in the decision;
7. persons standing in *loco parentis* to the patient; or
8. a majority of the patient's adult heirs at law who participate in the decision.

Ark. Code. Ann. § 20-17-214(a).

When the Declaration Becomes Operative

The declaration becomes operative when (1) it is communicated to the attending physician, and (2) the attending physician and another physician in consultation determine either that the patient is in a terminal condition and is no longer able to make decisions regarding administration of life-sustaining treatment or is permanently unconscious. Upon determining the patient is in a terminal or permanently unconscious condition, the attending physician is responsible for recording the determination and the terms of the declaration in the patient's medical record. If the attending physician or other health care provider is unwilling to comply with the declarant's wishes, then the patient must be transferred as promptly as possible to another physician or health care provider.

Ark. Code. Ann. §§ 20-17-203, 20-17-205, 20-17-207.

Even though a declaration has become operative, the physician or other health care provider is still responsible for providing treatment, including "nutrition and hydration, or both, for a patient's comfort, care, or alleviation of pain."

Ark. Code Ann. § 20-17-206(b).

The part of the Act requiring the attending physician to provide treatment, including nutrition and hydration, applies to both the permanently unconscious and the terminally ill. Two Arkansas Attorney General's Opinions have addressed this matter. (*See below*.)

Withholding or Withdrawing Nutrition and Hydration

Life-sustaining treatment may include, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration. There is no ethical distinction between withdrawing and withholding life-sustaining treatment. Under Arkansas law, the withdrawal of nutrition and hydration was a matter of considerable controversy since no Arkansas court had construed the Act. Revisions to the law in 2003 made it explicit that any patient who requests nutrition, hydration, or both, should have his wishes honored, but without the use of artificial means unless those means have been specifically requested. **(See Revocation**

of Declaration, below.) There are two published state Attorney General's opinions and one law review article on withdrawal of nutrition and hydration:

1. Attorney General's Opinion 87-215 dated June 30, 1987. This opinion concluded that section 20-17-206(b) does not permit the withdrawal of nutrition and hydration when the patient is permanently unconscious but not terminally ill.
2. Attorney General's Opinion 91-118 dated June 12, 1991. This opinion agreed with the previous Attorney General's opinion but recognized the patient's constitutional right to refuse unwanted medical treatment including nutrition and hydration. The opinion finally concluded that it was unable to provide a conclusive response.
3. Withdrawal of Nutrition and Hydration from Dying & Vegetative Patients: A Statutory Analysis of Arkansas Law by Robert B. Lefler, 1993 Ark. Law Notes 79. This paper concluded that "existing Arkansas law authorized the withholding and withdrawal of artificial nutrition and hydration in conformity with reasonable medical standards."

Revocation of Declaration

The declarant may revoke the declaration at any time and in any manner regardless of the declarant's mental or physical condition. The revocation is effective upon communication to any health care provider by the declarant or by a witness to the revocation. The revocation must be made a part of the patient's medical record. The wishes of a patient who asks for nutrition, hydration, or both, shall be honored. However, the law states that unless the use of artificial means is specifically requested, "a patient's request for nutrition or hydration, or both, shall not be honored by use of artificial means if doing so would require the insertion of any apparatus into the patient's body."
Ark. Code Ann. § 20-17-204.

Immunities

A physician or another health care provider who is unaware that a declarant has revoked his declaration will not be subject to civil or criminal liability or discipline for unprofessional conduct for carrying out the declaration.
Ark. Code Ann. § 20-17-208.

Penalties

A physician or any person who "willfully" interferes with a declaration is guilty of certain criminal acts, ranging from a Class A misdemeanor to a Class D felony. Also, a person who coerces or fraudulently induces another person to execute a declaration is guilty of a Class D felony. Failure to record the determination of a terminal or permanent unconscious condition and failure to transfer are misdemeanors.
Ark. Code Ann. § 20-17-209.

Miscellaneous Provisions

Death resulting from the intentional withdrawal of life-sustaining treatment does not constitute a suicide or homicide. Therefore, death in this manner has no legal effect on life insurance policies or annuities.

The law explicitly states that these provisions do not mean that Arkansas condones mercy killing or euthanasia.

A person may not prohibit or require the execution of a declaration as a condition for insurance or for receiving health care services.
Ark. Code Ann. §§ 20-17- 210, 214.

Durable Power of Attorney for Health Care

A person may execute a written document that delegates health care decision-making to another person. A durable power of attorney for health care gives control over personal care and health care to a person's agent when the person becomes incapacitated or disabled. There are specific requirements for, and limitations on, powers of attorney for health care.

The power of attorney for health care must be in writing, signed by the person giving the power of attorney, or by someone acting at the person's direction and in the person's presence, and attested to by two or more competent witnesses at least 18 years of age. The power of attorney may be "durable", which means that it is still operative, or becomes operative, when the person becomes incapacitated or disabled. Generally, in order to be a "durable" power of attorney, the document must contain language stating that the power of attorney either is not affected by the subsequent disability or incapacity of the person delegating the power or that the power of attorney is effective when the disability or incapacity occurs.
Ark. Code Ann. § 20-13-104; §§ 28-68-201.

Life-Sustaining Treatment Decisions

The law on durable powers of attorney for health care was not intended to alter or amend the Arkansas Rights of the Terminally Ill and Permanently Unconscious Act ("Terminally Ill Act"). *(See above.)* For that reason, a declaration (advance directive) governing the withholding or withdrawal of life-sustaining treatment is still needed even if a person has executed a durable power of attorney for health care. The power of attorney may contain the declaration (advance directive) as described in the Terminally Ill Act.

The law on health care powers of attorney, enacted in 1999, does not affect or invalidate any health care agency executed, or any act of an agent prior, to July 1, 1999.
Ark. Code Ann. § 20-13-104.

See Withholding or Withdrawing Nutrition or Hydration, this section, page 59.

Suicide

Assisted Suicide

It is against Arkansas law for any person to assist another in committing suicide. Purposely causing or aiding another person to commit suicide is classified as the crime of manslaughter, which is a Class C felony.
Ark. Code Ann. § 5-10-104.

Physician-Assisted Suicide

Physician-assisted suicide is a felony, punishable by imprisonment and fines. A physician or health care provider commits the criminal offense of physician-assisted suicide when he or she participates in a medical procedure or knowingly prescribes any drug, compound or substance to a patient for the express purpose of assisting the patient to intentionally end his or her life. This law does not prohibit physicians or health care providers from carrying out Advanced Directives or Living Wills nor does the law prohibit physicians from prescribing any drug, compound or

substance for the specific purpose of pain relief.
Ark. Code Ann. § 5-10-106, as amended by Act 827 of 2007.

Death of Long-term Care Facility Resident

Long-term care facilities are required to "immediately" report the death of any resident to the appropriate coroner or medical examiner, even in cases where facility staff believes the death to be from natural causes. The effect of this law is to require a report to the coroner in all deaths at a long-term care facility.

Additionally, if a long-term care resident dies at a hospital within five days of admission to the hospital, then the death must be reported immediately to the coroner by the hospital, even if the death is thought to be from natural causes.

The coroner or medical examiner shall accept the report for investigation, and if there is a finding of reasonable cause to suspect that the resident died as a result of abuse, sexual abuse or negligence, he shall report his findings to the police, the appropriate prosecuting attorney, and to the state Department of Human Services.

The coroner also shall report his findings to the hospital or nursing home making the report, unless the findings are part of a pending or ongoing law enforcement investigation.
Ark. Code Ann. § 12-12-1709.

Death of Hospice Facility Resident

Hospice facilities must immediately report the death of a resident to the appropriate coroner.
Ark. Code Ann. § 12-12-1709.

"Unexpected" Death of a Child

The Arkansas Child Death Review Panel is empowered to obtain information from medical care providers and others in connection with the "unexpected" deaths of children under the age of eighteen and to conduct reviews of those deaths. "Unexpected death" means the death of a child who has not been in the care of a licensed physician for treatment of an illness that is the cause of death; a diagnosis of Sudden Infant Death Syndrome, or death from an unknown cause.

Once the Panel requests information, a medical provider has 30 days to provide it, unless the death is under criminal investigation, prosecution or has been adjudicated in court. The Panel may access medical records and vital records in the custody of any health care provider or the Department of Health concerning the death that the Panel is reviewing.

The information furnished to the Panel is confidential, and the statute states the law is intended to conform to the requirements of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) by falling within HIPAA's public health, safety and law enforcement exceptions.

The records provided to the Panel are not accessible by subpoena or through any civil, administrative or other proceeding. However, the records are available to law enforcement agencies and prosecutors.

The law contains an immunity clause for persons who provide confidential records to the Panel "in good faith." Nevertheless, before providing records a physician may wish to consult legal counsel.

The purpose of the Panel, among other things, is to publish statistical reports, establish training criteria for county coroners, and perform public education.
Ark. Code Ann. § 20-27-1701 and following.

See also, Organ Donation at page 193; Vital Statistics- Vital Records - Contents -Release of Dead Body at 243; Vital Records - Death Certificates at 245; HIPAA at page 115; Sudden Infant Death Syndrome at page 238.

DEFIBRILLATORS

Non-medical businesses and individuals may acquire and use Automated External Defibrillators (AED) pursuant to guidelines revised in a 2005 law. Any person or entity that acquires an AED must notify an agent of emergency communications, 911, or vehicle dispatch center of the existence, location, and type of AED. All expected AED users must complete courses at least once every two years in CPR and AED use based on current scientific guidelines and recommendations for providing CPR and the use of AED's. The defibrillator must be maintained and tested according to the manufacturer's operational guidelines and instructions. Any person who uses an AED on a person in cardiac arrest must contact emergency medical services as soon as possible and must report the use to the medical provider responding to the emergency.

There is no requirement that a physician or medical authority be involved in a non-medical site's AED program.

Use and Tort Immunity

Any person or entity who in good faith and without compensation gives emergency treatment by the use of an AED is immune from civil liability for any personal injury stemming from the use of the AED, or as the result of any act or failure to act in providing or arranging further medical treatment, if the person acts as an ordinary, reasonably prudent person would have acted under the same or similar circumstances. This immunity from civil liability includes any physician or medical authority who is involved in the AED site placement; the person or entity that provides the CPR and AED training; and the person or entity who is responsible for the site where the AED is located or used.

Immunity from civil liability does not apply if the injury is the result of gross negligence or willful or wanton misconduct of the person rendering the emergency treatment.

These requirements do not apply to any individual using an AED in an emergency setting if that individual is acting as a Good Samaritan under state law at *Ark. Code Ann. § 17-95-101, as amended by Acts 683 and 1038 of 2007 or § 17-95-106.*
Ark. Code Ann. §§ 20-13-1301 to 1305.

See also, Good Samaritan Law at page 81.

DELEGATED MEDICAL PROCEDURES

In 2009, the Arkansas General Assembly authorized physicians and podiatrists to delegate the performance of some simple procedures to unlicensed employees who are trained to perform the procedures. The delegating physician or podiatrist remains responsible for the acts of the

employee performing the delegated medical practice.

The Arkansas State Medical Board is responsible for promulgating rules for physicians on delegation while the Arkansas Board of Podiatric Medicine is responsible for those regarding podiatrists. The statutes authorizing the delegation also set out the framework for the rules to be created by the two boards. Each board must establish standards to be met and procedures to be followed when a physician or podiatrist delegates "the performance of medical practices to a qualified and properly trained employee who is not licensed or otherwise specifically authorized" by Arkansas law to perform the practice. The State Medical Board has promulgated a regulation titled "Physician Delegation Regulation."

Any delegated medical practices must be performed under the delegating physician's or podiatrist's supervision. The employee performing the delegated practice must not be represented to the public as a licensed healthcare provider.

Delegation of Drug Administration

Delegated medical practices may include administration of drugs that do not require "substantial specialized judgment and skill based on knowledge and application of the principles of biological, physical, and social sciences" as determined by the two boards. Delegated drug administration may be performed only within the physical boundaries of the delegating physician's offices. There first must be an evaluation of whether the delegation is appropriate according to the acuity of the patient involved, and training and competency requirements must be met by the person administering the drugs. The State Medical Board and the Podiatric Medicine Board each may adopt further standards and procedures on delegated drug administration.

Prohibited Acts

The delegating physician or podiatrist may not transfer his supervision responsibilities to a health professional other than another physician. An unlicensed employee who has been delegated authority to administer drugs is prohibited from delegating that authority to another person. Administration of anesthesia may not be delegated.

Ark. Code Ann. §17-95-202; 17-96-202, as amended by Act 472 of 2009, codified at 17-95-208 and 17-96-204.

DO-NOT-RESUSCITATE ORDERS

See Emergency Medicare Care, Do-Not-Resuscitate Act at page 78.

DRUGS - CONTROLLED SUBSTANCES

Schedules of Controlled Substances

The Director of the Department of Health categorizes substances into separate schedules based on their potential for misuse and use in medical treatment. The Department of Health publishes a list of the substances which comprise Schedules I-VI. A 2009 draft proposed the addition of several drugs to the schedules, as listed below. Copies may be obtained by calling the Arkansas Department of Health, Division of Pharmacy Services and Drug Control, at (501) 661-

2325 or via the Internet. Certain substances appear in more than one schedule.

Schedule I: Substances with a high potential for abuse which have no accepted medical use in treatment in the United States or which lack accepted safety for use in medical treatment. Heroin and certain other opium derivatives and opiates; LSD, mescaline, peyote, and certain other hallucinogenics; methaqualone and gamma-hydroxybutyric acid (GHB), classified as depressants; and certain stimulants are examples of the numerous substances in this category.

Schedule II: Substances possessing a high potential for abuse that have accepted medical use in treatment in the United States or currently accepted medical use with severe restrictions, and which may "lead to severe psychic or physical dependence." Examples include codeine, methadone, oxycodone, certain stimulants and depressants and the hallucinogenic Nabilone. The 2009 draft adds tapentadol, an analgesic.

Schedule III: Substances with a potential for abuse less than those in Schedules I & II, which have currently accepted medical use in treatment in the United States and which "may lead to moderate or low physical dependence or high psychological dependence." Examples include anabolic steroids, certain stimulants, depressants and the hallucinogenic Dronabinol.

Schedule IV: Substances with a low potential for abuse relative to substances in Schedule III and which have currently accepted medical use in treatment in the United States and which may lead to "limited physical dependence or psychological dependence relative to the substances in Schedule III." Examples include diazepam, phenobarbital, carisoprodol (Stadol), butorphanol (Soma), nalbuphine (Nubain) and pentazocine (Talwin). A 2007 change in the law added the analgesic tramadol. The 2009 draft proposes to add fosprofol, a sedative/anesthetic, to this schedule. Schedule V: Substances which have a low potential for abuse relative to the controlled substances listed in Schedule IV, which have currently accepted medical use in treatment in the United States and which have "limited physical dependence or psychological dependence liability relative to the controlled substances listed in Schedule IV." Examples include medicines containing lower amounts of codeine or opium, the stimulant ephedrine and certain "ephedrine combination products", pseudoephedrine and phenylpropanolamine. The 2009 draft would add lacosamide, an anticonvulsant, to this schedule.

Schedule VI: Substances not currently accepted for medical use in treatment in the United States and for which there is a lack of accepted safety for use even under direct medical supervision and the substance "has relatively high psychological or physical dependence liability, or both" and use of the substance presents "a definite risk to public health." Substances in Schedule VI now include **only** marijuana, tetrahydrocannabinols, and their synthetic equivalent derivatives and isomers.

Ark. Code Ann. §§ 5-64-203 to 215, as amended by, Acts 558, 585 and 827 of 2007; List of Controlled Substances for the State of Arkansas and 2009 Draft.

Legend Drugs

The term "legend drug" refers to drugs that can only be dispensed by or upon a practitioner's prescription because the drug is habit-forming, is toxic or has a potential for harm and has certain limitations on its use. Ark. Code Ann. § 20-64-503. *Ark. State Board of Pharmacy Reg. 08-00-0001(d), (Rev. 07/2009).* The requirements for dispensing physicians who purchase legend drugs for patient use are discussed in Ark. Code Ann. § 17-95-102.

See Prescriptions, Physician Dispensing Act at page 207.

Drug Sample Distribution

A 2009 law establishes rules for the handling and use of drug samples. Drug samples may be provided to a patient only by a physician, a practitioner licensed to prescribe the drug, a health care professional acting at the direction and under the supervision of a physician or practitioner, or a pharmacy that has approval from the Arkansas State Board of Pharmacy to handle samples at the direction of a physician or practitioner.

Physicians and practitioners licensed to prescribe the drugs may receive drug samples from a manufacturer or authorized distributor by mail, common carrier, or by direct distribution by a company representative only upon the written request of the physician or practitioner. The written request must contain (1) the name, address, professional designation, and signature of the physician or practitioner; (2) the identity of the drug sample requested and the quantity requested; (3) the name of the drug manufacturer of the drug sample requested; and (4) the date of the request. The new law sets out additional requirements to be followed by drug manufacturers and distributors.

Act 943 of 2009, codified at Ark. Code Ann. §4-86-108.

Distribution and Prescription

Schedules I and II

Physicians must use an order form to transfer ownership or control of any substance in Schedule I or II to another physician for dispensing to patients.

In most circumstances, Schedule II substances may only be dispensed on written prescription from a physician unless the physician directly dispenses the substance himself to the ultimate user. However, Schedule II substances may be orally prescribed in emergency situations but the prescription must be "reduced promptly to writing and filed by the pharmacy." No prescription for a Schedule II substance may be refilled.

Schedule II Drugs for Narcolepsy, Hyperkinesis or Attention Deficit Disorder.

The Arkansas State Medical Board has imposed additional requirements for prescription of certain Schedule II drugs, including amphetamines and methamphetamines. A physician may write prescriptions for these drugs only for treatment of Narcolepsy, Hyperkinesis or Attention Deficit Disorder, with or without hyperactivity. No second or subsequent prescription may be written for these drugs until a second opinion is obtained from another physician confirming the diagnosis of Narcolepsy, Hyperkinesis or Attention Deficit Disorder and that the controlled drug is the drug of choice.

A physician who specializes in treatment of Hyperkinesis, Attention Deficit Disorder with or without hyperactivity, or Narcolepsy may apply to the board for exemption from the second opinion requirement. Violation of this regulation constitutes grossly negligent or ignorant malpractice.

Ark. State Medical Board Reg. 7, as amended June 14, 2001.

Schedules III and IV

Schedule III and IV substances may only be dispensed on written or oral prescription unless physicians directly dispense the substance to the ultimate user. The prescription must be filled within six months from the date of prescription and may not be refilled more than five times unless renewed by the physician.

Schedule III and IV Drugs for Obesity.

The State Medical Board imposes detailed requirements on the use of Schedule III and IV drugs for short-term treatment of obesity. (Schedule II drugs may not be used to treat obesity.) The wording of the regulation suggests that "short-term" means 90 days, but there are provisions in the regulation that may allow use of these drugs over a longer period if certain conditions are met. The regulation mandates that a treating physician never dispense or prescribe more than a 30-day supply of anorexiant drugs at a time. Also, the drugs should not be prescribed for a patient who has a Body Mass Index of less than 27.
Ark. State Medical Board Reg. 21.

Schedule V

Schedule V substances may only be dispensed and distributed for medical purposes.
Ark. Code Ann. §§ 5-64-307 to 308.

See Electronic, Facsimile and Oral Prescriptions at page 72; Electronic Prescriptions for Controlled Substances at page 74.

Inventory and Record Keeping Requirements

The rules and regulations of the Department of Health pertaining to controlled substances require physicians to keep a record of controlled substances received, administered, dispensed, or used in the profession other than by prescription. The rules do not specify a particular system or form for record keeping; however, the system used must meet the record keeping requirements. The record must indicate the date of receipt, the name and address of the person or business from whom received, and the kind and quantity of drugs received.

The record must show the drugs sold, administered, dispensed, or otherwise disposed of; the date on which the above occurred; the name and address of the person to whom or for whose use the drugs were sold, administered, or dispensed; and the name, strength and quantity of drugs. The names of research subjects participating in a research study of controlled substances may be withheld.

Physicians must maintain inventory records of all controlled drugs under the physician's control. The federal Drug Enforcement Agency (DEA) requires an inventory every two years. Records must be kept by the registrant for at least two years.

Records of Schedule I and II substances must be kept separately from all other records. Records of Schedule III, IV, and V substances must be kept either separately from all other records, or in such form that the information is readily retrievable from the ordinary business records for inspection and copying by agents of the Division of Drug Control, Arkansas Department of Health.

Copies of the *Rules and Regulations of the Arkansas Department of Health Pertaining to Controlled Substances* (Rev. July 28, 2005) may be obtained by calling the Arkansas Department of Health, Division of Pharmacy Services and Drug Control, at (501) 661-2325. The rules and regulations include:

Registration
Exempt Preparation
Security Requirements

Procedure in Case of Loss
Classification of Controlled Substances
Records of Controlled Substances
Surrender of Unwanted Controlled Substances
Controlled Drug Prescriptions/Orders
Schedule II Prescriptions
Violations
Suspension, Revocation
Labeling

Drug Precursors

The Department of Health publishes a list of drug precursors. Although a license is normally required to possess drug precursors, physicians may lawfully possess them without a license.
Ark. Code Ann. § 5-64-415, as amended by Act 827 of 2007.

Drug Enforcement Agency Numbers

A 1999 law prohibits insurance companies and HMOs from requiring physicians, pharmacists, or other persons to disclose a physician's Drug Enforcement Administration registry number "for the purposes of identification, payment to a pharmacist, reimbursement of a patient, or any other reason."
Ark. Code Ann. §§ 23-66-701 to 702.

Restrictions on Ephedrine, Pseudoephedrine, Phenylpropanolamine

These drugs were added to Schedule V by a 2005 law, which also set further limits on possession and sale of medicines containing these drugs, only some of which are summarized here. However, certain products containing these drugs are exempt from the Schedule V classification.

Possession

With certain exceptions, it is unlawful for an individual to purchase, acquire or receive within any 30-day period, or at any time to possess, more than five grams of ephedrine or nine grams of pseudoephedrine or phenylpropanolamine or their salts, optical isomers, and salts of optical isomers, alone or in a mixture. Possession in violation of this provision constitutes evidence of the intent to manufacture methamphetamine or another controlled substance. Pharmacists and other authorized persons who offer the above products upon prescription or pursuant to the Federal Food, Drug, and Cosmetic Act are exempt. Also exempt are physicians, dentists, veterinarians, podiatrists, and other health care professionals with prescriptive authority who administer the above drugs to their patients, as well as licensed manufacturers, wholesalers, and distributors of the drug who meet certain requirements.

Pharmacy Real-Time Electronic Logbook

In an effort to reduce the manufacture of methamphetamines in Arkansas, pharmacies must record all sales of ephedrine, pseudoephedrine, and phenylpropanolamine in a centralized real-time electronic logbook, maintained by the Arkansas Crime Information Center, called MethMonitor. The real-time log is designed to allow rapid detection of purchasing activity that may indicate manufacture of methamphetamines. The information in the electronic logbook is

confidential and not subject to the Freedom of Information Act. Physicians are among those persons permitted access to the logbook for the purpose of "providing medical or pharmaceutical care." Access is provided through the Arkansas Crime Information Center at (501) 682-2222. The law imposes penalties for unauthorized access to the information and for improper disclosure of the information. Federal law also sets out procedures and record keeping requirements for the sale of these products. *Ark. Code Ann. § 5-64-1101; § 5-64-212 as amended by Act 508 of 2007 codified at Ark. Code Ann. §§5-64-1103, 5-64-1104 and following.*

Treatment for Chronic Intractable Pain

Arkansas' Chronic Intractable Pain Treatment Act sets statutory standards physicians must follow when treating a patient with chronic intractable pain. However, the Arkansas State Medical Board's position continues to be that physicians must follow its Regulation 2, Paragraph 6 (as amended in 2008), on use of dangerous drugs and controlled substances when treating patients with chronic intractable pain and that the more stringent requirements of Reg. 2 should be followed by physicians.

State Medical Board Regulations on Controlled Drugs and Pain

Under State Medical Board Reg. 2, Paragraph 6, the treatment of pain "with dangerous drugs and controlled substances is a legitimate medical purpose when done in the usual course of medical practice." If the provisions of this regulation are met and "if all drug treatment is properly documented, the Board will consider such practices as prescribing in a therapeutic manner, and prescribing and practicing medicine in a manner consistent with public health and welfare."

What a Physician May Not Do.

A physician who prescribes certain narcotics from Schedule II, III, IV and V for more than six months to a "patient with pain not associated with malignant or terminal illness will be considered" as exhibiting "gross negligence or ignorant malpractice" unless the physician has complied with the requirements set out below. The narcotics covered exclude Schedule IV Propoxyphene products, Ultram, and Tramadol but include Talwin, Stadol and Nubain. Prescribing such drugs for more than six months is considered as prescribing them "on a long term basis."

What a Physician is Required to Do.

In order to avoid running afoul of Reg. 2, any physician who prescribes the above-described drugs for more than six months must: (1) keep accurate records to include medical history, physical exam, other evaluations and consultations, treatment plan objective, informed consent noted in patient record, treatment, medications given, agreements with the patient and periodic reviews; (2) periodically review the course of schedule drug treatment of the patient and any new information about the etiology of the pain. (If the patient has not improved, the physician must assess the appropriateness of continued prescribing of scheduled drugs, dangerous drugs or trial of other modalities.) (3) obtain written informed consent from any patient the physician is concerned may abuse controlled substances and discuss the risks and benefits of use of controlled substances with the patient, his guardian or authorized representative; (4) be "licensed appropriately in Arkansas" and have a valid controlled substance registration and comply with all federal and state regulations for issuance of controlled substances and prescriptions.

The Medical Board's Regulation 19 concerns requirements for physicians operating Pain Management Programs.

See Arkansas State Medical Board Regulations at page 41.

The Chronic Intractable Pain Treatment Act of 2003

This law provides that physicians may not be disciplined by the State Medical Board "solely for prescribing dangerous or controlled drugs for the relief of 'chronic intractable pain'", which is defined as "a pain state for which the cause of the pain cannot be removed or otherwise treated, and for which no relief or cure has been found after reasonable efforts by a physician." The law sets out standards that physicians must follow.

The phrase "dangerous or controlled drugs" means pain relief drugs, such as opioids and those on Schedules II, III, IV or V. The term does not include substances that are illegal to prescribe under federal law.

Pain Management Review Committee. The law created a Pain Management Review Committee, appointed by the State Medical Board. Any allegation of improper prescribing "determined to require a board hearing" must first be reviewed by the committee. The board must timely provide the committee with all necessary documentation for the review process. (However, it is possible that in "exceptional limited substantive instances requiring immediate action to protect the public health", the Board could take action without a first review by the committee.) The committee is charged with using criteria set out in the statute to review a physician's conduct in prescribing, administering, ordering or dispensing pain medications and other drugs to treat chronic intractable pain. The committee is authorized to develop guidelines for investigations of complaints, to review complaints "on an individual patient-needs basis" regarding physicians treating chronic intractable, pain and it is authorized to provide an "objective critique" to the State Medical Board "for board determination".

After a board hearing, "in lieu of a finding of gross and ignorant malpractice," the board may "incrementally impose sanctions" including monitoring of the physician's prescribing habits, requiring continuing medical education hours, requiring the physician to surrender his DEA license to the Medical Board for a period not exceeding three months, and suspending or revoking the physician's license.

In situations where an allegation of improper prescribing does not justify a board hearing, then in lieu of a hearing, the board may refer the physician to the Pain Review Committee "for review and recommendations to the board." Under these circumstances, the review and recommendations will not "adversely affect the physicians' license or licensure status."

The committee must include representation from the Arkansas Osteopathic Medical Association, the Arkansas Medical Society, and the Arkansas Pain Society. In furtherance of the statute's purpose "to ensure a fair, impartial, and objective board hearing", a member of the State Medical Board may not be "present while the committee reviews allegations of improper prescribing" nor be "involved in any way in the committee's deliberations."

The statute's provisions on pain treatment. The law states, that "based upon evaluation and management of a patient's individual needs, a physician may": (1) Treat a patient with chronic intractable pain with a dangerous or controlled drug; (2) continue to treat the patient for as long as the pain persists; (3) treat the pain by managing it with dangerous or controlled drugs in amounts or combinations that may not be appropriate for treating another medical condition; (4)

administer large doses of dangerous or controlled drugs for pain management if the benefit of relief outweighs the risk of the large dose; (5) administer a large dose of a dangerous or controlled drug even if its use may increase the risk of death, if the purpose is not to cause or assist in a patient's death.

A physician may not: (1) prescribe or administer dangerous or controlled drugs intended to manage chronic intractable pain to treat a patient for chemical dependency; (2) prescribe or administer dangerous or controlled drugs intended to manage chronic intractable pain to a person the physician knows to be using drugs for nontherapeutic purposes; (3) prescribe or administer dangerous or controlled drugs to a person for other than legitimate medical purposes; (4) cause or assist in causing the suicide, euthanasia or mercy killing of any individual.

However, the statute explains "causing or assisting in the suicide, euthanasia, or mercy killing of any individual does not include prescribing, dispensing, or administering medical treatment for the purpose of alleviating pain or discomfort even if that use may increase the risk of death so long as the treatment is not furnished for the purpose of causing or assisting in causing the death of the individual."

Ark. Code Ann. § 17-95-701 and following,

See also, Human Growth Hormone at page 124; Prescriptions, Physician Dispensing Act at page 207; Insurance Coverage for Certain Cancer Drugs at page 133; Pharmacy Practice at page 201; Physician Assistants at page 203.

ECONOMIC CREDENTIALING

"Economic credentialing" or "conflict of interest policies" are terms used to describe the practice by some hospitals of denying staff privileges to physicians based on the physicians' financial investments in medical facilities that the hospital considers a competitor. Economic credentialing policies require physicians to agree not to invest in a "competitor" in return for staff privileges.

Under economic credentialing, hospital staff membership is no longer based solely on professional competency. Some policies are broadly drafted such that if a physician's family member has an ownership interest in a "competing" facility, the hospital will deny staff privileges to the physician. A denial of hospital privileges not only prevents the physician from admitting patients to the hospital, he also will be barred from using the hospital's outpatient and testing facilities, such as imaging centers.

Economic credentialing strikes at the core of the physician-patient relationship. It first permits hospitals to unilaterally determine whether another facility is a "competitor". It then allows hospitals to deny access to their facilities and thus, in many cases, deprive the patient of the ability to use his chosen physician when they need or desire admittance to the hospital denying the privileges.

Economic credentialing enables hospitals to use staff membership as a weapon to control physicians' investments and thereby attempt to control the marketplace of health related services. Physicians fear that hospitals will expand economic credentialing policies to exclude physicians from staff when the physicians own or invest in ancillary enterprises that hospitals view as a threat, such as imaging centers and ambulatory surgical centers.

General medical-surgical hospitals began enacting economic credentialing policies after physicians began investing in cardiology, neurology or other "specialty" hospitals.

Arkansas is at the forefront of the battle over economic credentialing because the state's largest hospital system, Baptist Health, enacted such a policy, which was then challenged in court. In 2009, a Pulaski County Circuit Court permanently prohibited Baptist Health from enforcing its economic credentialing policy, finding that the policy was void as against Arkansas public policy, was unconscionable, and therefore was unlawful and unenforceable. (*Baptist Health v. Bruce E. Murphy, M.D., et al*.) Baptist Health appealed this ruling to the Arkansas Supreme Court, where the case is currently.

The American Medical Association's Code of Medical Ethics § 4.07 "Staff Privileges" specifically states that "fear of competition" should not play a role in granting or denying staff privileges. The AMA opposes the use of economic criteria unrelated to patient care to grant hospital privileges.

ELECTRONIC, FACSIMILE AND ORAL PRESCRIPTIONS

It is important to recognize that electronic, facsimile and oral prescriptions are covered by regulations issued by the state Department of Health, the state Pharmacy Board, state statutes, federal laws and federal regulations from the Drug Enforcement Agency. In addition, laws on Medicare Part D prescription drug coverage also addresses electronic prescribing. **See Electronic Prescriptions Under Medicare Part D at page 77**. Because of the complexity of this area of the law and the fact that these laws and regulations are anticipated to undergo further revisions, legal counsel should be consulted when questions arise.

Schedule II

Arkansas and federal law requires practitioners to manually sign all prescriptions for Schedule II drugs, with exceptions for emergencies. *Ark. Code Ann. § 5-64-308.* Because an electronically transmitted prescription, such as from computer to computer, would not be manually signed, practitioners may not electronically transmit prescriptions for Schedule II drugs. However, in an emergency, a practitioner may orally authorize a pharmacist to dispense Schedule II drugs, as long as certain requirements are met. The quantity prescribed and dispensed must be limited to an amount adequate to treat the patient during the emergency period, which can never exceed 72 hours. An "emergency" exists when the practitioner determines that immediate administration of the Schedule II drug is needed for proper treatment, there is no appropriate alternative treatment available, and it is not reasonably possible for the practitioner to provide a written prescription to the pharmacist prior to the dispensing of the drug. Within seven days of authorizing an emergency oral prescription, the practitioner must provide the pharmacist with a written prescription for the amount dispensed. The statement "Authorization for Emergency Dispensing" and the date of the oral order must be on the face of the prescription. If the practitioner fails to provide the written prescription within the seven days, the pharmacist is obligated to notify the federal Drug Enforcement Agency.

Ark. Code Ann. *§ 5-64-308, Ark. Board of Pharmacy Reg. 07-04-0001 (Rev. 07/2009); Ark. Dept. of Health Rules and Regs. Pertaining to Controlled Substances, Section VIII E (July 28, 2005).*

Facsimile transmissions of Schedule II drugs are permissible in limited circumstances: (a) for home infusions and/or I.V. pain therapy patients; (b) for long-term-care facility residents; and (c) for home hospice patients.
Ark. Code Ann. § 5-64-308; Arkansas Department of Health Rules and Regulations Pertaining to Controlled Substances, Section VIII, G. (July 28, 2005); Ark. Board of Pharmacy Reg. 07-00-0001(Rev. 07/2009).

Schedules III, IV and V

Arkansas regulations and federal law permit both oral and facsimile transmissions of prescriptions for Schedule III, IV and V drugs. According to the Arkansas Board of Pharmacy, the facsimile must be of a manually signed prescription signed only by the prescribing practitioner and transmitted directly to the pharmacy. An oral prescription may be made by the practitioner or his agent and then promptly reduced to writing by the pharmacist, according to the Pharmacy Board. *Ark. Board of Pharmacy Reg. 07.00.0001(c)(1)(Rev. 07/2009)*

While the state Pharmacy Board has enacted regulations that address electronic transmission of prescription drug orders to pharmacies, it is the current position of the DEA that no Schedule III, IV, or V drug prescription may be electronically transmitted. (Facsimiles are not considered electronic transmissions.) However, it is expected that someday the DEA will revise its regulations to permit electronic transmissions of prescriptions. Under Medicare Part D, prescription drug plans must support electronic prescribing; however, it is optional for the provider to use electronic prescribing under Part D. .

The Pharmacy Board rules on electronic prescriptions state a prescription drug order may be transmitted to a pharmacy by an electronic transmission, as long as certain requirements are met. *Phar.Reg. 07-00-0008*(c)(1) (*Rev. 07/2009*). The Pharmacy Board also does not consider a facsimile to be an "electronic transmission."

"Electronic transmission" is defined as "transmission of information in electronic form such as computer-to-computer, electronic device to computer, e-mail, or the transmission of the exact visual image of a document by way of electronic equipment." *Phar Reg. 07-00-0008*(a)(2)*(Rev. 07/2009).* Any prescription that is electronically transmitted must be "immediately reduced to a form, by the pharmacist, that may be maintained for the time required by law or rules." It must be transmitted directly to the pharmacy by the authorized practitioner or his agent, and the identity of the transmitting agent must be included. *Phar. Reg. 07-00-0008(c) (Rev. 07/2009)*

The Arkansas Board of Pharmacy regulations permit any pharmacist to "exercise professional judgment" regarding the accuracy, validity, and authenticity of an electronically transmitted prescription "consistent with existing federal or state laws or regulations." *Phar. Reg. 07-00-0008*(c)(3) *(Rev. 07/2009).*

Practitioners are referred to the DEA Practitioner's Manual (August 2006) for general guidance, while Pharmacists are referred to the DEA Pharmacist's Manual (April 2004) for general guidance. The manuals are available at www.deadiversion.usdoj.gov/pubs/manuals/index.html.

See Electronic Prescriptions for Controlled Substances, below, and Electronic Prescriptions for Medicare Part D, at page 77.

ELECTRONIC PRESCRIPTIONS FOR CONTROLLED SUBSTANCES

The Controlled Substances Act of 1970, 21 U.S.C. § 801 and following, vested the responsibility for regulating the manufacture and distribution of controlled substances in the Drug Enforcement Administration (DEA) Office of Diversion Control (ODC). Although DEA's current regulations do not allow for electronic transmission of prescriptions for controlled substances, the DEA is continuing to develop standards for electronic transmission of prescriptions through a secure mode, using Public Key Infrastructure technology, as explained below. Proposed regulations have been published. ***The DEA does not consider facsimiles to be "electronic transmissions" so the DEA's regulations on facsimile prescriptions continue to apply.***

To determine the status of the DEA regulations, check the DEA's official website: www.deadiversion.usdoj.gov. Electronic prescribing of controlled substances will not be permitted until federal regulations are formulated and adopted. Once the regulations are adopted, practitioners will still be able to issue prescriptions manually, whether or not they participate in the electronic transmission system.

The DEA has set out an Anticipated Standard for electronic transmission of prescriptions for controlled substances, as discussed below.

Proposed Regulations

The regulations proposed in June 2008 would permit physicians to write prescriptions for controlled substances electronically and would enable pharmacies to receive, dispense, and archive electronic prescriptions.

In the proposed regulations, the DEA sets out various security requirements in connection with creating, signing, transmitting, processing, and dispensing electronic controlled substance prescriptions.

Physicians and pharmacists would be required to review a log of their controlled substance prescriptions on a daily basis. The regulations also would require that physicians and pharmacists retain and maintain records of electronic prescriptions for five years.

These proposed regulations on this subject are only guidance and notice of the DEA's intentions as to electronic prescriptions.

Electronic Prescriptions for Controlled Substances, 73 Federal Register 36722 (June 27, 2008) (proposed amendments to 21 Code of Federal Regulations Parts 1300, 1304, 1306, & 1311).

Public Key Infrastructure Technology

The federal regulations will require participating practitioners and pharmacies to use Public Key Infrastructure (PKI) technology to digitally sign electronic transmissions of prescriptions for controlled substances. PKI is a mathematical, computational system that (1) maintains the privacy of the information contained in transmissions; (2) ensures that neither the sender nor the receiver of the transmission is an impostor; and (3) protects the integrity of the message against subsequent alteration. PKI uses "public key cryptography" and a "digital signature" to achieve those results.

Public Key Cryptography

"Cryptography" is the system of transforming information (in its "plaintext" form) into a coded form (known as "ciphertext") that a receiver can de-code and read only if the receiver

possesses the appropriate "key." A key is a mathematical parameter that transforms the information from one form into the other. The process of transforming plaintext into ciphertext is called "encryption," and the process of transforming ciphertext back into plaintext is called "decryption."

Cryptography can be either symmetric or asymmetric. Users of symmetric cryptography both possess the same "secret key," which they use to encrypt and decrypt data transmissions. Asymmetric cryptography, also known as "public key cryptography," involves the use of two different keys — a "public key" and a "private key." A user distributes the public key to those who will receive the user's data transmissions, while the user keeps the private key.

In the public key system, both the public key and the private key are capable of encrypting and decrypting information, but only these two keys can work together. In other words, only the user who has the private key can decrypt information that has been encrypted with the public key, and vice versa. A user who possesses one key cannot computationally or mathematically determine the other key's formula.

Digital Signature and Electronic Signature

A digital signature is not the same thing as an electronic signature. An **electronic signature** is any type of on-line signature, regardless of whether or not it is protected by coding.

A **digital signature** enables a receiver to verify (1) that the message was not modified after the sender signed it; and (2) that the sender is who he purports to be.

First, the sender "hashes" the message by running it through a mathematical process that generates a "digest code." The digest matches the message and will change if the message changes. After generating the digest code, the sender encrypts it with his private key. The encrypted digest is the sender's "digital signature." The sender then attaches this "signature" to his message and sends the message, with the signature, to the receiver.

Upon receiving the transmission, the receiver checks the identity of the sender by attempting to decrypt the signature using the public key that corresponds to the sender's private key. If the public key works, then the sender's identity is verified because the public key will decrypt only a signature that the corresponding private key encrypted.

The receiver then calculates a new message digest from the original message. If the new digest matches the digest that accompanied the message, then the document has not been changed since it was signed.

Certification Authorities

A Certification Authority (CA) issues "digital certificates" to practitioners. A digital certificate is a public key that the CA has digitally signed, transforming the public key into a form that other users can trust. These certificates will allow the practitioner to electronically transmit prescriptions for all schedules of controlled substances. Practitioners enrolled in the electronic prescription for controlled substances system ("EPCS") will also be able to use their digital certificate to transmit prescriptions for noncontrolled substances. Available on the DEA website, www.deadiversion.usdoj.gov, is a January 26, 2009, Certificate Policy (Version 2.2) that spells out in more detail how the certificates will be issued and the technical and other requirements of the process. The DEA will not issue certificates directly to practitioners, but instead will issue certificates to a Certification Authority, which in turn will provide digital certificates to practitioners who meet certain requirements.

Participating Practitioners

Only DEA-registered practitioners will be eligible to obtain digital certificates. Practitioners must apply to an approved CA of their choice. DEA-registered practitioners will be permitted to prescribe controlled substances electronically only after the application has been approved, the practitioner has signed a "Subscriber Agreement" with the CA, and the CA has issued a digital certificate to the practitioner.

Practitioners will be obligated, among other things, to protect the private key as set out in the Subscriber Agreement; take all reasonable measures to prevent its loss, disclosure, modification or unauthorized use, and notify the issuing CA in a timely manner if they suspect their private key is compromised or lost. The Anticipated Standard, available on the DEA website, states that the PKI system must protect the private key from unauthorized access by use of a biometric authentication device, such as a fingerprint.

The CA has the authority to suspend or revoke a practitioner's digital certificate.

Practitioner's Computer Systems

Applicants' computer systems must provide and support PKI technology. The system must provide the ability to digitally sign all electronically transmitted controlled substance prescriptions using the practitioner's digital certificate. The system must automatically prompt the practitioner and must transmit the practitioner's digital certificate along with the prescription. Vendors of PKI-enabled software, as well as pharmacies that develop their own software, will be required to annually audit the systems to ensure they are working properly. Other requirements are set out in the Anticipated Standard and in the Certificate Policy.

The DEA explained in the Anticipated Standard that it is aware there are already numerous commercial systems that allow practitioners to transmit prescriptions electronically. Once it becomes legal to electronically transmit prescriptions for controlled substances, the DEA expects system vendors to make their systems comply with the final DEA standards for electronically prescribing controlled substances.

EPCS Participating Pharmacies

Before accepting a prescription, pharmacies must verify that the electronic prescription has not been altered and that it is not a forgery and must reject fraudulent or altered prescriptions, and pharmacies must check the status of the practitioner's digital certificate and reject the prescription if the certificate has been revoked. The pharmacy must also verify that the practitioner is authorized to prescribe the appropriate schedule of controlled substances and reject the prescription if the practitioner does not have the proper authorization. Also, the pharmacist must electronically sign the electronic prescription so that the pharmacist can be bound to the act of filling the prescription. Finally, the pharmacy must maintain an electronic archive of electronic prescriptions for two years.

Elements of an Electronic Prescription

Under the Anticipated Standard, electronic prescriptions must contain the full name and address of the patient; the drug name, strength, dosage form, quantity prescribed and directions for use; the name, address and registration number of the practitioner. All prescriptions for controlled substances must be dated as of, and signed on, the day when issued.

Electronic Prescriptions for Controlled Substances - Overview; Public Key Infrastructure Analysis: Electronic Prescriptions for Controlled Substances Concept of Operations;

Anticipated Standard for DEA Electronic Transmission of Prescriptions for Controlled Substances System; DEA Diversion Control E-Commerce PKI Certificate Policy, all prepared for DEA by PEC Solutions, Inc., and available at: www.deadiversion.usdoj.gov.

ELECTRONIC PRESCRIPTIONS UNDER MEDICARE PART D

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA"), which provides prescription drug coverage for Medicare recipients, also permits electronic prescribing of drugs through the Part D program. The Part D electronic prescription standards supersede any state law or regulation on electronic prescribing that is contrary to the standards or restricts the ability to carry out electronic prescribing of Part D drugs. Although e-prescribing is optional for physicians and pharmacies, Medicare requires drug plans participating in the prescription benefit to support electronic prescribing.
42 U.S.C. § 1395w-104(e).

Regulations and Disincentives

The final e-prescribing rule for Part D, published in April 2008, provided three tools for use in e-prescribing: 1) formulary and benefit transactions (gives physicians information about which drugs are covered by a Medicare beneficiary's prescription plan); 2) medication history transactions (provides physicians information about medications a beneficiary is already taking, including those prescribed by other physicians); and 3) fill status notifications (allows physicians to receive an electronic notice from the pharmacy telling them the status of a patient's prescription). This rule also adopted the National Provider Identifier (NPI) for e-prescribing under Part D as well as retired NCPDP SCRIPT 5.0 in favor of NCPDP SCRIPT 8.1.

Entities and practitioners transmitting prescriptions by computer-generated facsimiles are exempt from the requirement to use the NCPDP SCRIPT Standard adopted in the regulations. However, this exemption will be eliminated when the e-prescribing disincentives take effect in January 2012 under the Medicare Improvements for Patients and Providers Act of 2008 ("MIPPA"). *See below.*
Overview E-Prescribing, available at www.cms.hhs.gov/EPrescribing; 42 Code of Federal Regulations §423.160(a)(3)

Grants for Physicians

The MMA authorizes matching grants to physicians to assist them in implementing electronic prescription drug programs for Medicare Part D. Physicians must apply to the Social Security Administration for the grants. Preference will be given to physicians who serve a rural or underserved area, and special consideration will be given to physicians who serve a disproportionate number of Medicare patients. Only one grant will be made per physician or physician group. The grant money must be used for purchasing, leasing, or installing computer software and hardware; making upgrades and other improvements to existing computer software and hardware to enable e-prescribing, and training physicians and staff on use of the technology. Physicians must provide at least 50% of the costs of the project through "non-federal contributions", in cash or in kind. As another condition for the awarding of the grant, physicians

must share information with the government to permit it to evaluate the project and ensure the money was properly used.
Public Law 108-173, Sec. 108, Dec. 8, 2003, 117 Stat. 2172.

ELECTRONIC PRESCRIPTIONS UNDER MEDICARE PART B

Medicare Part B covers physician office visits and other out-patient services. Medicare has devised the "MIPPA" program to encourage physicians to use electronic prescribing when they write prescriptions as a part of an evaluation and management visit.

Incentives and Penalties under MIPPA

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorized an incentive program for eligible physicians who are "successful" electronic prescribers as defined by MIPPA. Reporting periods are one year in length, and the incentives are based on the covered professional services furnished by eligible physicians during that year.

This program, which began in January 2009, defines a successful e-prescriber as an individual eligible professional who reports one e-prescribing measure in at least 50% of the cases in which the measure is reportable during the reporting year. Limitations on participation include that the physician must use a qualified e-prescribing system and certain requirements involving the codes for the covered services.

MIPPA provides a 2% bonus in 2009 and 2010 for e-prescribing, and a 1% bonus in 2011 and 2012. Physicians who do not successfully e-prescribe in 2012 and thereafter will receive the fee schedule amount reduced by a penalty of 1% in 2012, 1.5% in 2013, and 2% in 2014 and future years. A hardship exemption may be available to those practitioners who are unable to use a qualified e-prescribing system.
Overview E-Prescribing Incentive Program; Statute/Regulations E-Prescribing Incentive Program; Eligible Professionals E-Prescribing Incentive Program, all available at www.cms.hhs.gov/ERXIncentive . Public Law 110-175.

See also Prescriptions, Internet and Electronic Mail and Telemedicine at 211.

EMERGENCY MEDICAL CARE

Do-Not-Resuscitate Act

"Do-not-resuscitate" means to withhold the administration of cardiopulmonary resuscitation (CPR) in the event of cardiac or respiratory arrest. Usually, do-not-resuscitate information may be found in a standardized identification card, form, necklace or bracelet approved by the State Health Department. The identification means the patient has executed an "advanced directive" (written declaration) expressing his desire not to be resuscitated in the event of a cardiac or respiratory arrest or it means that the patient's attending physician has issued a DNR Order for the patient.
Ark. Code Ann. § 20-13-901.

CPR includes the following treatment techniques: "cardiac compression, endotracheal

intubation and other advanced airway management, artificial ventilation, defibrillation, administration of cardiac resuscitation medications, and related procedures."

Types of Emergency Treatment Allowed

Do-not-resuscitate orders only proscribe the use of CPR unless they specifically state other techniques to be withheld. DNR orders may never be used to authorize withholding treatments "short of CPR", such as intravenous fluids, oxygen, nutrition, hydration, and other therapies. ***See Arkansas Rights of the Terminally Ill and Permanently Unconscious Act at page 58.***

Do-not-resuscitate orders may not include the withholding of any treatment designed to provide comfort care or alleviate pain.

The patient may at any time request CPR treatment and thereby override a previous DNR.
Ark. Code Ann. §§ 20-13-901, 905.

Emergency Medical Personnel

Emergency medical personnel are authorized to follow do-not-resuscitate orders to withhold CPR from an adult patient who suffers cardiac or respiratory arrest in a pre-hospital setting unless the patient expresses a desire to be resuscitated before the arrest occurs.

The DNR order must be available to the emergency medical personnel in a format approved by the State Department of Health. Emergency medical personnel include firefighters, law enforcement officers, first responders, emergency medical technicians, or other emergency service personnel acting within the course of their profession.

Immunity

No civil or criminal liability, or unprofessional conduct results when a physician, emergency medical personnel, or health care facility withholds or withdraws CPR from persons bearing do-not-resuscitate identification. This immunity covers persons acting under the physician's authority. Further, immunity exists when a person bearing do-not-resuscitate identification requests CPR and the health care provider complies.
Ark. Code Ann. § 20-13-902.

Duty to Transfer Patients Identified by Do-Not-Resuscitate Orders

Physicians or health care facilities refusing to comply with a valid do-not-resuscitate order must take the steps necessary to transfer the patient to another physician or health care facility that will comply with the order. Willfully failing to transfer a patient constitutes a Class A misdemeanor.

Physicians and health care facilities may not require a person to procure a do-not-resuscitate order before receiving medical treatment.
Ark. Code Ann. §§ 20-13-904 to 905.

Out-of-State Advance Directives

Advance directives executed in another state are valid in Arkansas. The directives must have been executed in compliance with the laws of the originating state or the laws of the State of Arkansas.
Ark. Code Ann. § 20-13-907.

Penalties

A person falsifying, forging, concealing, canceling, obliterating, or defacing a do-not-resuscitate order or revocation commits a criminal act which may be classified as a Class D felony or a Class A misdemeanor. Withholding personal knowledge of a revocation with the intent to cause the withholding or withdrawal of CPR is a Class D felony.
Ark. Code Ann. § 20-13-908.

Immunity for Withholding CPR Without a DNR Order in Certain Circumstances at a Long-Term Care Facility

In circumstances involving an unwitnessed death, a 2009 law permits licensed nurses employed at a long-term care facility to withhold cardiopulmonary resuscitation from residents of the facility, regardless of the presence or absence of a DNR order. CPR may be withheld if there is "clear and unmistakable" dependent lividity or rigor, and if (1) respirations are absent for at least 30 seconds; (2) carotid pulse is absent for at least 30 seconds; (3) lung sounds auscultated by stethoscope bilaterally are absent for at least 30 seconds, and (4) both pupils, if accessible, are not nonreactive to light. These conditions must be noted in the resident's record.

Long-term care facilities and its employed licensed nurses are not liable for administrative sanctions, civil damages, or criminal prosecution based on the withholding of CPR. Also, a person who acts in good faith reliance of a long-term care facility's or an employee of the facility's withholding cardiopulmonary resuscitation is not liable for administrative sanctions, civil damages, or criminal prosecution for the person's actions.

Act 718 of 2009, codified at Ark. Code Ann. § 20-17-104.

Emergency Treatment of Insect Stings and Nerve Agent Exposure

When a physician is not available, "certified personnel" may treat certain persons suffering from insect stings, other allergic reactions, or exposure to nerve agents. Certified personnel receive training and instruction from licensed physicians. For example, a scout master may be certified to administer treatment to a scout.

The Department of Health provides the appropriate certificate forms to instructing physicians. Instructing physicians must file a copy of all issued certificates with the Department of Health.

Authority to Treat Reactions to Insect Stings and Other Allergic Reactions

A person, by virtue of a special relationship to another person, whether occupational or volunteer, such as a parent or teacher, may be certified to recognize the symptoms of adverse reaction to an insect sting and other allergic reactions and to administer epinephrine in an emergency. Any physician may issue the proper prescription and paraphernalia for insect sting and other allergic reaction treatment to the certificate holder.

Authority to Treat Reactions to Nerve Agents

Persons certified to recognize the symptoms of adverse reaction to a nerve agent and trained to administer atropine/pralidoxime (or other approved drugs) may administer the prescribed treatment in an emergency. Any physician may issue the proper prescription and paraphernalia

for nerve agent treatment to the certificate holder.

Immunity from Liability

Physicians and certificate holders possess immunity from suit for acts and omissions performed in "good faith" while treating reactions to insect stings or nerve agents. This immunity does not apply when the physician's or certificate holder's "conduct amounts to gross negligence." Good faith means acting with "honest intent."

Courts have defined "gross negligence" in a variety of ways, but gross negligence may be understood as a failure to observe even slight care, and carelessness or recklessness to a degree that shows utter indifference to the consequences that may result.

Ark. Code Ann. §§ 20-13-401 and following, as amended by Act 684 of 2009; §§ 20-13-601 and following

Needlestick and Sharps Safety

Arkansas hospitals are required to purchase needleless systems and/or sharps with engineered sharps injury protections for all high-risk areas in an effort to lessen health industry workers' risk of contracting blood-borne diseases such as HIV and hepatitis B and C.

"High-risk areas" are defined as emergency rooms, operating rooms, and intensive care units in acute-care hospitals.

"Needleless system" means devices that do not use needles for collection or withdrawal of bodily fluids after initial venous or arterial access is established; for administrations of medication or fluids, or for any other procedure involving the potential for occupational exposure to blood borne pathogens from an injury from a contaminated sharp.

"Sharps with engineered sharps injury protection" means a non-needle sharp or needle device with built-in safety feature or mechanism that effectively reduces the risk of an exposure accident.

Pre-filled syringes approved by the federal Food and Drug Administration will not be subject to the provisions of this law until July 2005.

Ark. Code Ann. § 20-9-311.

See also, Occupational Exposure to Blood or Other Potentially Infectious Materials at page 193.

Good Samaritan Law

Under the Good Samaritan law, any physician who renders emergency care in good faith at the scene of an accident or emergency is immune from liability for any damages. The statute provides that any health care professional who "in good faith, lends emergency care or assistance without compensation at the place of an emergency or accident, shall not be liable for civil damages for acts or omissions performed in good faith as long as any act or omission resulting from the rendering of emergency assistance or services was not grossly negligent or willful misconduct."

School Athletic Events

Similarly, health care professionals, who in good faith and without compensation, render emergency aid to a participant in a school athletic event for an injury suffered in the event, cannot be held liable for damages unless they commit an act or omission constituting "gross

negligence."
Ark. Code Ann. § 17-95-101, as amended by Acts 683 and 1038 of 2007.

See also, Civil Immunity at page 43.

Poison Control and Drug Information

Physicians needing emergency information for proper treatment of persons suffering from the use or misuse of dangerous substances may call the UAMS College of Pharmacy Poison and Drug Information Hotline at (800) 376-4766 or (501) 686-6161. Further research material may be obtained from the UAMS Library.

Immunity

The College of Pharmacy personnel are covered by an immunity provision for information "proffered in . . . any good faith professional effort to effectuate the purposes" of the law on emergency drug information.

Penalties

Persons who obtain or attempt to obtain information fraudulently or for illegal purposes are guilty of a misdemeanor crime. Conviction results in a fine that will not exceed $500, or imprisonment for up to six months, or both.
Ark. Code Ann. §§ 20-13-701 and following

Requested Medical Assistance

Physicians and institutions possess immunity from liability for good faith acts when providing specialized equipment or personnel at the request of a city, county, or state. The immunity only covers aid provided without compensation.
Ark. Code Ann. § 16-120-401.

Infectious Disease Testing and Emergency Response Workers

A 2009 law eliminates any requirement to obtain consent to test for potentially life-threatening airborne or blood-borne diseases in certain situations. A physician still must order the testing. A health care provider or health care facility may test an individual when an employee of that provider or facility has a type of contact with the individual that may transmit an airborne or blood-borne disease, as determined by a physician's medical judgment. The law appears intended to apply to "emergency response workers" as well, which are defined as "paramedics, emergency response employees, firefighters, first response workers, emergency medical technicians, emergency medical services personnel, volunteers making an authorized emergency response, and a person rendering services as a Good Samaritan.

Potentially life-threatening airborne or blood-borne diseases include Tuberculosis, Hepatitis C and Hepatitis B. "Health care provider" can mean any physician, nurse, paramedic, or other person providing medical, nursing, or other health care services of any kind. A health care facility is defined as "a hospital, nursing home, blood bank, blood center, sperm bank, or other health care institution."

The results of the disease testing must be provided by the physician who ordered the test to (1) the affected health care provider's physician or the employee's physician and (2) the

physician of the individual who was tested.

Notwithstanding any other law to the contrary, a person who performs the test or a person who discloses a test result are not subject to civil or criminal liability for doing so.

Act 1185 of 2009, codified at Ark. Code Ann. §20-13-1501 and following.

See also, Service by Retired Physicians at page 231.

EMERGENCY MEDICAL TREATMENT AND LABOR ACT

Anti-Dumping Act

The Emergency Medical Treatment and Labor Act (EMTALA) arose in response to the practice among some private hospitals of refusing treatment to indigent patients in emergency rooms or transferring indigent patients from their emergency rooms to public hospitals, thereby acquiring its common name, the "anti-dumping act."

The Act applies to any hospital with an emergency department, whether the emergency department is located on or off the main hospital campus.

The Federal Department of Health and Human Services and the Centers for Medicare & Medicaid Services issued Revised EMTALA Interpretive Guidelines dated May 29, 2009, which contain detailed explanations and examples illustrating EMTALA violations and appropriate compliance. The Guidelines can be found at http://www.cms.hhs.gov/EMTALA/.

A hospital's EMTALA obligation ends, when a physician or qualified medical person has made a decision that no emergency medical condition exists (even though an underlying medical condition may persist); or that an emergency medical condition exists and the individual is then appropriately transferred to another facility; or that an emergency medical condition exists and the individual is admitted to the hospital for further stabilizing treatment.

Dedicated Emergency Department

EMTALA regulations define "dedicated emergency department" as any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus that meets one of the following requirements:

1. It is licensed by the state as an emergency room or emergency department;
2. It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
3. It provides at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

In the dedicated emergency department, the requirement to provide a Medical Screening Exam ("MSE") is triggered when there is a request for examination or treatment by an individual or by someone on the individual's behalf. In the absence of a request, the requirement for an MSE is triggered if a prudent lay person would believe that the patient requires evaluation or treatment of a medical condition.

If emergency services are not provided at the hospital, the governing body must ensure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate. If emergency services are provided at the hospital but are not provided at one or more off-campus departments of the hospital, the governing body of the hospital must ensure that the medical staff has written policies and procedures in effect with respect to how to handle patients in need of immediate care.

The regulations require these hospitals with emergency departments to provide an MSE to anyone coming to the emergency department for treatment to determine whether an emergency medical condition exists. These screening examinations are predicated on uniform screening protocols that the hospital has developed for different types of patient complaints. If an emergency medical condition is determined to exist, the hospital must provide any necessary stabilizing treatment.

Non-applicability of EMTALA. During a national emergency, a hospital with a dedicated emergency department that is located in the emergency area will not be sanctioned for making a transfer or diversion that otherwise would violate EMTALA's transfer requirements, if certain requirements are met. Hospitals in the area of the national emergency still would be required to provide medical screening examinations to persons who requested examination or treatment, according to the May 29, 2009, Revised EMTALA Interpretive Guidelines from the federal Department of Health and Human Services and the Centers for Medicare & Medicaid Services.

The Medical Screening Examination and Who Performs It

Hospitals must provide an appropriate medical screening (any screening the hospital would have offered to any paying patient) to individuals who come to the emergency department for treatment or examination. The May 29, 2009, Revised EMTALA Interpretive Guidelines explain that the medical screening examination is the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether an emergency medical condition does or does not exist. The MSE is an ongoing process that begins with triage and is appropriate to the individual's presenting signs and symptoms, as well as the capability and capacity of the hospital. The medical record must reflect continued monitoring until it is determined whether or not the person has an emergency medical condition and, if so, until the patient is stabilized or appropriately transferred. Triaging is not equivalent to a medical screening examination, according to the Interpretive Guidelines, since triaging merely determines the order in which patients will be seen and not the presence or absence of an emergency medical condition.An MSE must be conducted by an individual who is qualified according to the hospital's by-laws or rules and regulations. The hospital's governing body should approve a document that sets forth the designation of the qualified medical professionals who may perform an MSE. Informal personal appointments are not allowed.

Emergency Medical Condition

The Act defines an emergency medical condition as one: . . . manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part; . . . or with respect to a pregnant woman who is having contractions, (i) that there is inadequate time to

effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

"Stabilized" and "Stable and Ready for Discharge"

The regulations define "to stabilize" an emergency medical condition as meaning to provide such medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer. With respect to a pregnant woman in labor, "to stabilize" means she has completed delivery of the child and the placenta. To be considered stable the emergency medical condition that caused the individual to seek care in the emergency department must be resolved, although the underlying medical condition may persist.

A patient is considered "stable and ready for discharge" when, within reasonable clinical confidence, it is determined that the individual has reached the point where his continued care, including diagnostic work-up and/or treatment, could be reasonably performed as an outpatient or later as an inpatient, provided he is given a follow-up care plan. Some patients, rather than being discharged upon stabilization, will be admitted as an inpatient for continued care.

Transfers

An appropriate transfer under EMTALA requires that:

1. The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health, and in the case of a woman in labor, the health of the unborn child;
2. The receiving facility has has available space and qualified personnel to treat the patient and has agreed to accept transfer of the individual and to provide appropriate medical treatment;
3. The transferring hospital sends with the patient all available medical records relating to the emergency condition, including test results (test results may be sent later if still pending), the patient's or a legally responsible person's informed consent to the transfer, and, if applicable, the name and address of any on-call physician who failed or refused to appear within a reasonable time to provide stabilizing treatment; and
4. The transfer is effected by qualified personnel and transportation equipment, including the use of necessary and medically appropriate life support measures.

Note that the receiving facility in a transfer does not have to have en emergency department. If it has specialized capabilities and capacity, the hospital is obligated to accept the transfer of a patient with an emergency medical condition.

If a patient has not been stabilized, the hospital may not transfer the patient unless the transfer meets the requirements listed above and (1) the individual or a legally responsible person consents to the transfer, (2) a physician certifies that the benefits of receiving treatment at another medical facility outweigh the risks from being transferred, or (3) another qualified medical person certifies to the information above after consultation and agreement by a physician.

Use of Dedicated Emergency Department for Non-Emergency Services

If an individual comes to a hospital's dedicated emergency department and requests

treatment, but the nature of the request makes it clear the medical condition is not an emergency, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.

Inpatients

EMTALA regulations define "inpatient" as an individual who is admitted to the hospital for bed occupancy for purposes of receiving inpatient hospital services, with the expectation that he or she will remain at least overnight and occupy a bed. EMTALA does not apply once the decision has been made in good faith to admit a patient to the hospital as an inpatient. However, if it is found that a hospital is attempting to avoid EMTALA obligations by admitting patients and then immediately discharging them, then EMTALA could continue to apply. EMTALA does not apply to any inpatient who was admitted to the hospital for elective (non-emergency) diagnosis or treatment.

Minors

The 2009 Guidelines make it clear that minors can receive medical screening examinations without parental consent. The Guidelines state that, if requested by a minor or on the minor's behalf, hospitals must conduct the examination to determine if an emergency condition exists and that hospital personnel should not delay the examination by waiting for parental consent. If the screening shows that no emergency is present, the staff can wait for parental consent before proceeding with further examination and treatment.

Delay in Examination or Treatment

Participating hospitals may not delay providing appropriate medical screening examinations or treatment in order to inquire about the individual's method of payment or insurance status. In addition, a participating hospital may not seek authorization from the individual's insurance company for screening or stabilization services until after the hospital has provided the appropriate medical screening examination and initiated any further medical examination and treatment that may be required to stabilize the emergency medical condition.

An emergency physician or non-physician practitioner is not precluded from contacting the individual's physician at any time to seek advice regarding the individual's medical history and needs that may be relevant to the medical treatment and screening of the patient, as long as this consultation does not inappropriately delay services.

Hospitals may follow reasonable registration processes for individuals for whom examination or treatment is required, including asking whether an individual is insured and, if so, what that insurance is, as long as that inquiry does not delay screening or treatment. Reasonable registration processes must not unduly discourage individuals from remaining for further evaluation.

Right to Refuse or Request Transfer

The Act provides that patients have the right to refuse treatment, to refuse transfer, and to request transfer. The hospital must attempt to get the patient's signed informed statement refusing to follow the hospital's recommendation.

Availability of On-Call Physicians

Each hospital must maintain an on-call list of physicians on its staff available for duty after the initial examination to provide necessary treatment to stabilize a patient with an emergency medical condition. A hospital is not necessarily required to have a physician in a particular specialty on-call on a twenty-four-hour, seven-day-a-week basis, and no physician is required to be on call at all times. The 2009 Guidelines explain that the call list is intended to identify and ensure that the emergency department knows in advance which physicians, including specialists and subspecialists, are available to provide emergency care. Physician group names are not acceptable for identifying the on-call physician. Individual names must be used.

The 2009 Guidelines provide hospitals flexibility regarding how to configure an on-call coverage system. One option is a Community Call Plan (CCP). Under a CCP, a hospital may augment its on-call list by including physicians at another hospital. A CCP can be configured in various ways, but it will allow hospitals to provide more on-call specialty coverage than they would on their own. The hospital where an individual initially presents still has its EMTALA obligation to conduct a MSE and provide stabilizing treatment. However, if the appropriate specialist under the CCP is on duty at another hospital in the CCP, the hospital can make an appropriate transfer and will be considered to have provided treatment within its capability and capacity. A CCP plan must establish the geographic parameters of the CCP and must specify that all hospitals in the plan are not relieved of their EMTALA transfer responsibilities because of their inclusion in the CCP.

Hospitals may allow physicians to be on call at one more than one hospital at the same time. However, if a hospital permits such simultaneous call, then it must have written policies and procedures to follow when the on-call physician is not available because he or she has been called to another hospital.

Hospitals may allow physicians to perform elective surgery or other procedures while they are on-call. However, that physician and hospital must have planned back-up in the event the physician is called while performing elective surgery.

EMTALA does not require that every hospital on the medical staff must take call. If a hospital allows physician to selectively take call only for their own established patients, the hospital must have a back-up plan that maintains adequate on-call services as required by EMTALA.

A hospital's on-call policies and procedures must be written and must clearly define the responsibilities of the on-call physician. The policies must address the steps to be taken if a particular specialty is not available or the on-call physician cannot respond due to circumstances beyond his control. If the hospital employs a CCP, simultaneous call, or elective procedures while on-call, the policies and procedures must provide a backup plan for each of these arrangements.

If a staff physician is on call to provide emergency services or to consult with an emergency room physician in his or her area of expertise, that physician will be considered to be available at the hospital. A determination as to whether the on-call physician must physically see the patient in the emergency room is the decision of the treating emergency physician. His or her ability and medical knowledge of managing that particular medical condition will determine whether the on-call physician must come to the emergency department. In circumstances where the patient's geographic location makes it impossible for the on-call doctor to physically assess the patient, telemedicine services may be used. Telemedicine will be permissible in situations such as when a patient presents to an originating hospital located in a rural health professional shortage area or

in a county outside of a metropolitan statistical area. (Hospitals should determine whether they are eligible to use telemedicine without violating EMTALA and inform their medical staff of the determination.)

When a physician is on call for the hospital while he is seeing patients in his private office, it is generally not acceptable to refer emergency cases to his office for examination and treatment of an emergency medical condition. The on-call physician must come to the hospital to examine the patient if requested by the treating emergency physician. However, if it is medically appropriate to do so, the treating emergency physician may send an individual needing the services of the on-call physician to the physician's office if the office is on the hospital campus and the office is part of a hospital-owned facility, such as a hospital department that has the same Medicare provider number as the hospital itself. In determining whether a hospital acted appropriately under EMTALA in sending a patient to an on-call physician's office, CMS will consider whether all persons with the same medical condition were moved in such circumstances, regardless of their ability to pay, whether there was a bona fide medical reason to move the patient and whether appropriate medical personnel accompanied the patient.

Physician Violations of EMTALA

If an on-call physician does not come to the hospital when called and repeatedly directs the patient to be transferred to another hospital where the physician can treat the individual, the physician may have violated EMTALA. Whether or not a particular transfer violated the law may depend on the patient's needs and the physician's circumstances at the time he ordered the transfer.

Physicians who refuse to be on a hospital's on-call list, but who selectively take call for patients with whom they or a colleague have established a doctor-patient relationship, while at the same time refusing to see other patients, may violate EMTALA.

If a physician on call does not meet his obligation to the hospital, he may have violated EMTALA, even if the hospital arranged for care to be provided to the patient by another physician.

A physician who is called by the hospital to provide emergency screening or treatment, and who either refuses or fails to arrive within the response time set out by hospital policies or medical staff bylaws, may be in violation of EMTALA. The hospital's policies or staff bylaws must state an expected response time in terms of minutes. Terms such as "reasonable" or "prompt" are not sufficient.

Ambulance Services

A hospital's EMTALA obligations are triggered when an air or ground ambulance it owns and operates is transporting a patient to it for purposes of obtaining treatment at the hospital's dedicated emergency room.

However, a hospital's EMTALA obligations are not triggered in certain situations, such as if the ambulance it owns is operated under a communitywide protocol that directs it to transport patients to the closest appropriate facility. In such a case, the patient will be deemed to have presented himself at the emergency department of the hospital to which he was transported. Also, the hospital's EMTALA obligations are not triggered if the ambulance is operated at the direction of a physician who is not employed by or otherwise affiliated with the hospital that owns the ambulance. Finally, a hospital's EMTALA obligations are not triggered if the ambulance is non-hospital-owned, unless the ambulance has come onto that hospital's property

with the patient.

The hospital may deny access to non-hospital owned ambulances if the hospital is in "diversionary status," which means it does not have the staff or facilities to accept additional emergency patients. If, however, the ambulance staff ignores the hospital's refusal and transports the patient onto hospital property, the hospital's EMTALA obligations are triggered and it must take the patient.

Violations

Under the applicable regulations, when there is reason to believe there has been an EMTALA violation, a hospital is required to report to the Centers for Medicare and Medicaid Services within 72 hours of receiving an "improperly transferred" patient. However, the Revised EMTALA Interpretive Guidelines state that a report also should be made if the hospital "suspects" an improper transfer.

Should a hospital violate a provision of this Act, the hospital may be liable not only to the patient injured as a result of the hospital's action, but also to the receiving hospital for any financial loss suffered as a result of the transferring hospital's violation. The Act provides that a civil monetary penalty of not more than $50,000 for each violation may be assessed against both the participating hospital and responsible physician. Non-compliance with EMTALA can lead to provider termination from the Medicare program.

42 U.S.C. § 1395dd; 42 Code of Federal Regulations § 489.24.

Arkansas Definition of Emergency Medical Care

Arkansas has a state law similar to the federal "Anti-Dumping Act". Under the Arkansas law, "emergency medical care" is defined as "health care services provided in a hospital emergency facility to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in: (A) Placing the patient's health in serious jeopardy; (B) Serious impairment to bodily functions; or (C) Serious dysfunction of any bodily organ or part." The law provides that once a person qualifying for emergency medical care presents to an emergency department, that person shall be evaluated by medical personnel.

Ark. Code Ann. § 20-9-309 (emphasis added).

EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT

In 2009 Arkansas enacted the Uniform Emergency Volunteer Health Practitioners Act (*Act 432 of 2009, codified at Ark. Code Ann. §§12-87-101 and following*). The law is intended to prevent delays providing health care following a disaster. It establishes a mechanism for allowing out-of-state health care practitioners to practice in Arkansas during a declared emergency without receiving an Arkansas license. The law became effective October 1, 2009.

Definitions

Under this Act, an emergency means an event or condition that is a catastrophe caused by either natural or human forces that the Governor or the Director of the Arkansas Department of

Emergency Management determines to be, or threatens to be, of sufficient severity and magnitude to warrant state action or assistance.

A volunteer health practitioner means a health practitioner who provides health services, whether or not the practitioner receives compensation for those services. With some exceptions, the term does not include a health practitioner who receives compensation pursuant to a preexisting agreement or employment relationship with a host entity or affiliate that requires the practitioner to provide health services in Arkansas.

A host entity means an entity operating in Arkansas that uses volunteer health practitioners to respond to an emergency.

Applicability

This Act applies to volunteer health practitioners registered with a registration system and who provide health services in Arkansas for a host entity while an emergency declaration is in effect.

A volunteer health practitioner registration system must (1) accept applications for the registration of volunteer health practitioners before or during an emergency; (2) include information about the licensure and good standing of health practitioners that is accessible by authorized persons; (3) be capable of confirming the accuracy of licensure and good standing information before health services are provided; and (4) be designated by the Arkansas Department of Emergency Management as a registration system.

Regulation of services

When an emergency declaration is in effect, the Department of Health may limit, restrict, or otherwise regulate the duration of practice by volunteer health practitioners, the geographical areas in which they may practice, the types of volunteer health practitioners who may practice, and any other matters necessary to coordinate effectively the provision of health services during the emergency.

A host entity that uses volunteer health practitioners to provide health services in Arkansas must consult and coordinate with the Department of Health to the extent practicable to provide efficient and effective use of the volunteer health practitioners and comply with all other laws.

While an emergency declaration is in effect, the Arkansas Department of Emergency Management, their agent, or a host entity may confirm whether volunteer health practitioners utilized in Arkansas are registered with an authorized registration system. The confirmation is limited to obtaining the identities of the practitioners and that the practitioners are licensed and in good standing.

Out of State Volunteer Health Practitioners

While an emergency declaration is in effect, a volunteer health practitioner who is registered with an out-of-state registration system that meets Arkansas standards and who is licensed and in good standing in the state in which the practitioner's registration is based, may practice in Arkansas to the extent authorized under this law. A volunteer health practitioner is not entitled to the protections of this law if the licensure of the practitioner has been suspended or revoked, if the privileges of practice have been limited or restricted, or if the practitioner has been voluntarily terminated under the threat of sanctions.

This law does not authorize a volunteer health practitioner to provide services that are outside

the practitioner's scope of practice, even if a similarly licensed practitioner in Arkansas would be permitted to provide the services.

Credentialing and Privileging

This act does not affect credentialing or privileging standards of a health facility and does not preclude a health facility from waiving or modifying those standards while an emergency declaration is in effect.

Limitations on Civil Liability

A volunteer health practitioner who receives $500 or less per year compensation for providing health services is not liable for damages from an act or omission in providing health services. Reimbursement, or allowance for, reasonable expenses; or continuation of salary, or other remuneration while on leave do not count as compensation.

The law does not provide protection from liability for damages from: (1) willful misconduct or wanton, grossly negligent, reckless, or criminal conduct; (2) intentional torts; (3) breach of contract; (4) claims asserted by a host entity or another entity which employs the practitioner; or (5) acts or omissions relating to the operation of a motor vehicle, vessel, aircraft, or other vehicle.

Workers' Compensation

If a registered volunteer health practitioner is injured or dies as a result of providing health services during an emergency situation, then that practitioner is deemed to be an employee of the state and will receive benefits under the Arkansas Workers' Compensation or Occupational Disease law of Arkansas if the practitioner is not eligible for such benefits under the law of another state, and if the practitioner or his personal representative makes a claim under the Worker's Compensation or Occupational Disease law of Arkansas, and if the practitioner was acting under the control or direction of an Arkansas governmental agency.

Administrative Sanctions

If a volunteer practitioner provides services outside his scope of practice or provides services in violation of an order of the Arkansas Department of Emergency Management, an Arkansas licensing board or other Arkansas disciplinary authority may impose administrative sanctions for (1) out-of-state conduct by an Arkansas-licensed practitioner in response to an out-of-state emergency; (2) conduct in Arkansas by an out-of-state-licensed practitioner in response to an Arkansas emergency. Additionally for out-of-state practitioners, the Arkansas licensing board or disciplinary authority must report the administrative sanction to the out-of-state licensing board or disciplinary authority.

The law states that when any licensing board or disciplining authority determines whether to impose the administrative sanctions, it should consider the circumstances of the conduct and the practitioner's scope of practice, education, training, experience and specialized skills.

Act 432 of 2009, codified at Ark. Code Ann. §§ 12-87-101 and following; Ark. Code Ann. §§12-75-107, 108.

ERISA

The federal Employee Retirement Income Security Act (ERISA) was enacted in 1974 to create minimum standards for pension funds and health benefit plans. The adoption of ERISA

was spurred by events in the 1960s and 1970s in which poorly funded or mismanaged pension funds were unable to pay benefits to workers.

ERISA generally applies to private employers who offer pension or health benefit plans. Certain governmental employers and religion-connected plans are not covered. ERISA does not require employers to offer plans, but if a covered employer does offer a plan, it must follow ERISA's requirements. ERISA established funding standards, participation and pension vesting requirements, and standards of conduct for the plan, including mandatory reports and disclosures. ERISA also imposed certain fiduciary duties on plan administrators and created a civil enforcement mechanism.

ERISA law is a complex area that involves the interplay of the concepts of federal preemption of state law, the ERISA "savings" clause and the ERISA "deemer" clause. In general, ERISA preempts state laws that "relate to" any employee benefit plan, with some exceptions. Under the "savings clause," state laws on insurance, banking, securities, domestic relations orders, and general criminal laws are not pre-empted. However, the "deemer" clause imposes a significant limitation on the insurance exception: state law cannot be used to regulate employer self-funded insurance plans. This means that a plan may escape ERISA regulation by being self-insured (self-funded).

In 2004, the United States Supreme Court ruled that patients who are covered by ERISA health care plans, and who allege the plan caused them to receive substandard medical care, cannot sue the plan for money damages in state court. Patients are limited to the limited remedies provided in the federal ERISA statute.
Aetna Health v. Davila, 542 U.S. 200 (2004).

See also, Any Willing Provider at page 130, Insurance at page 128.

FAMILY PLANNING

Abortion

Clinic Regulations

A clinic that is set up for the primary purpose of performing abortions must be licensed by the Department of Health, Division of Health Facility Services. Application for a license may be obtained from the Department of Health. Licenses are renewable annually, by January 2, on payment of a licensing fee of up to $1000 per facility.

The Department of Health provides regulations for and periodically inspects the facility, equipment, procedures, techniques, and conditions of the clinic.

Ark. Code Ann. § 20-9-302; Arkansas Department of Health Rules and Regulations For Abortion Facilities (1999).

Abortion by Licensed Medical Practitioner

Only physicians licensed in Arkansas may perform abortions in Arkansas. The person assuming responsibility for the final disposition of the dead fetus must obtain the parents' authorization on a form prescribed by the state registrar. Physicians must treat the disposal of fetal remains as they would any other tissue.

Ark. Code Ann. § 5-61-101; § 20-18-604; § 20-17-802.

Public Funding

Amendment 68 of the Arkansas Constitution provides that "no public funds will be used to pay for any abortion, except to save the mother's life." Courts have found that a conflict exists between Amendment 68 and federal law concerning use of Medicaid funds, and federal law prevails to the extent of the conflict.

Abortion of a Viable Fetus

Unless necessary for the preservation of the life or health of the mother, or in the case of rape or incest of a minor, Arkansas law prohibits abortion of a "viable fetus." Abortion is defined as the intentional termination of a pregnancy "with an intention other than to increase the probability of a live birth or to remove a dead or dying fetus." The law presumes a fetus can live outside the womb after the end of the twenty-fifth week of pregnancy. Before a physician may perform an abortion after the fetus becomes viable, he first must certify in writing that the abortion is necessary to preserve the life or health of the mother, the medical indications for the abortion, and the probable health consequences.

Method or technique. A physician who performs an abortion on a woman carrying a viable fetus must use a method that is most likely to preserve the life and health of the fetus, unless this method would present a greater risk to the life and health of the mother. The physician is required to certify, in writing, the abortion methods considered, and the reasons for choosing the method employed.

Attendance of additional physician. When a physician performs an abortion of a viable fetus, an additional physician must be present who can take immediate control of the fetus' medical care.

Ark. Code Ann. §§ 20-16-702 to 703, 705 to 707.

"Partial-Birth" Abortions

The federal Partial Birth Abortion Ban Act, which prohibited and criminalized "partial-birth" abortions, was upheld as constitutional by the United States Supreme Court in *Gonzales v. Carhart, 127 S.Ct. 1610 (2007),* which found that the law was constitutional because the ban did not place an undue burden on a woman's right to an abortion since there are alternative abortion procedures that can be used if necessary.

The term "partial-birth" abortion under the federal law means an abortion in which the person performing the abortion (a) deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered fetus; and (b) performs the overt act, other than the completion of delivery, that kills the partially delivered living fetus. Under the Act, any physician who knowingly performed a partial-birth abortion and thereby killed a human fetus faced a mandatory fine or imprisonment of not more than two years, or both. This law did not apply to a partial-birth abortion necessary to save the mother whose life was endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself. A woman upon whom a partial-birth abortion was performed could not be criminally prosecuted. *18 U.S.C. § 1531.*

The ruling of *Gonzales v. Carhart*, *127 S.Ct. 1610 (2007)*, and the federal Partial Birth Abortion Ban Act preempts any inconsistent state law and applies nationwide.

In 2009, the General Assembly passed again enacted a partial-birth abortion ban. (The state's 1997 law banning the practice was struck down as unconstitutional.) The 2009 law uses the same standards as the federal law on prohibiting partial-birth abortions, except those necessary to save the life of a mother whose life is endangered. Under the 2009 state law, any person who knowingly performs a partial-birth abortion is guilty of a Class D felony. The woman upon whom the partial-birth abortion was performed is not subject to prosecution. The Arkansas State Medical Board may assess civil fines against the physician, ranging from $25,000 to more than $100,000 depending on number of violations. The Board also may suspend or revoke the physician's license.

The 2009 state law permits the physician to be sued for civil damages, but prohibits assessing damages against the woman upon whom the partial-birth abortion was performed. Those who may sue are: (1) the father, if married to the mother at the time she received the partial-birth abortion, and (2) the maternal grandparents of the fetus, if the mother was younger than eighteen at the time of the abortion. However, neither the father nor the grandparents may recover damages if the pregnancy was a result of their own criminal conduct or if they consented to the abortion. Damages authorized by the 2009 law are monetary damages for all psychological and physical injuries "occasioned by violation" of this law and damages equal to three times the cost of the partial-birth abortion.

Act 196 of 2009, codified at Ark. Code Ann. §20-16-1201 and following.

Requirements for Informed Consent

A physician who contemplates performing an abortion must first obtain the woman's voluntary and informed consent, and the law sets out very specific requirements that must be met before consent is "voluntary and informed." Except in the case of a medical emergency, consent will be deemed voluntary and informed only if the woman receives all of the information set

forth below, and confirms that in writing.

The Arkansas State Medical Board has promulgated Reg. 26 concerning abortions. The State Health Department has promulgated "Rules and Regulations for Abortion Facilities".

Information that Must Be Provided by Live Communication. Before performing the abortion and in no event on the same day as the abortion, the physician, the physician's agent, or a referring physician must give the woman the following information, either in person or by telephone: (a) the name of the physician who will perform the abortion; (b) the medical risks that are associated with the particular method the physician will employ; (c) the fetus's probable gestational age at the time the abortion will be performed; (d) the medical risks attendant on carrying the fetus to term; and (e) that a spouse, boyfriend, parent, friend, or other person cannot force her to have an abortion. The physician may deliver this information without conducting a physical examination or tests of the woman and may base the information given on facts the woman supplies or on any other information that is reasonably available to the physician. Although the physician may provide this information by telephone, he may not do so by tape recording. Any phone call used to provide the information must be a "consultation" in which the physician or his agent is able to ask questions of the woman and she is able to ask questions of the physician.

If, after the physician provides this information, the physician discovers new information that, in his medical judgment, requires revision of the previously given information, he may communicate that new information to the patient at any time before performing the abortion.

Information that May Be Provided by Tape Recording. The physician, his agent, or a referring physician must also provide the following information, before the abortion and in no event on the same day as the abortion, in person or by telephone: (a) medical assistance benefits may be available for prenatal care, childbirth, and neonatal care; (b) the father is liable to assist in supporting the child even if the father has offered to pay for an abortion; (c) the patient may review certain materials provided by the Department of Health, discussed below; (d) the State of Arkansas provides those materials; (e) the materials describe the fetus and provide a list of agencies that offer alternatives to abortion; (f) if she chooses to review those materials in print, they will be mailed to her; and (g) if she chooses to review those materials via the Internet, she will be given the specific address of the Internet website. All of the information required in this section may be provided by tape recording, so long as the machine is set up to record whether or not the woman chooses to review the Department of Health's informational materials.

Ark. Code Ann. § 20-16-901, and following, as amended by Act 1605 of 2007, Act 952 of 2009; Arkansas State Medical Board Reg. 26, adopted June 7, 2002.

Pain Awareness Act Informational Requirements

Under the Unborn Child Pain Awareness and Prevention Act, in all cases except those involving a medical emergency, at least 24 hours before an abortion is performed on a fetus whose probable gestational age is 20 weeks or more, the physician or his agent must inform the woman by telephone or in person that she may view certain printed materials on fetal pain, that these materials are available on a state-supported website, and the address of the website. The physician or the physician's agent shall orally inform the woman that the materials have been provided by the State of Arkansas and that they contain information on pain in relation to the unborn fetus. If the pregnant woman chooses to view the materials other than on the website, the materials shall either be given to her at least 24 hours before the abortion or mailed to her at least

72 hours before the abortion by certified mail, restricted delivery to addressee. If provisions are made to record or otherwise register specifically whether the woman does or does not choose to have the printed materials given or mailed to her, the information may be provided by a tape recording.
Ark. Code Ann. § 20-16-1101 and following.

Requirements for Use of Ultrasound.

All physicians who use ultrasound equipment must inform the woman she has the right to view the ultrasound image before the abortion is performed. The physician must certify in writing that the woman was given an opportunity to view the image, and the physician must obtain in writing the woman's signed acceptance or rejection of the offer to view the image. The physician must keep his certification and the woman's signed acceptance or rejection for three years.

If the woman accepts the offer and requests to view the ultrasound image, she must be allowed to view it.

Failure to inform the woman of the right to view the image or failing to allow her to view the image may subject the physician to disciplinary action by the Medical Board.
Ark. Code Ann. § 20-16-602.

Informational Materials

The Arkansas Department of Health must provide the following materials and make them available in print and on the Internet: (1) either geographically-indexed materials that include (a) a list of public and private agencies available to assist the woman throughout her pregnancy and thereafter, including adoption agencies; (b) a description of the services those agencies offer; and (c) either a description of the manner in which those agencies may be contacted, including their phone numbers; or a twenty-four-hour-a-day toll-free number that the woman may call to obtain, orally, a list and description of the agencies in the caller's location; and (2) materials that inform the woman of the fetus's probable anatomical and physiological characteristics at two-week gestational increments, starting at the beginning of pregnancy through full term. These materials must include (a) any relevant information on the possibility of the fetus's survival; and (b) pictures or drawings representing the fetus's incremental development. Such pictures or drawings must describe the fetus's dimensions and must be realistic and appropriate for the stage of pregnancy depicted. The information must be objective, nonjudgmental, and designed to convey only scientific information about the fetus; the materials must describe (a) the commonly-employed methods of terminating pregnancy; (b) the medical risks associated with each method; (c) the possible detrimental psychological effects associated with abortion; and (d) the medical risks associated with carrying the fetus to term.

Under the Unborn Child Pain Awareness and Prevention Act, the Department also must provide materials and an Internet site on pain and fetuses.

The Department must provide these materials, free of cost, in English and in each language that is the primary language of two percent or more of the state's population. The Department must update the materials annually.

The information required to be distributed by the physician to the patient may be obtained by the Arkansas Department of Health at (501) 661-2121.
Ark. Code Ann. §§20-16-904, 20-16-1105.

Mandatory Written Certifications

Before the physician performs the abortion, the patient must certify in writing that she has received all of the above-detailed required information and that she has been given a choice of whether to review the materials provided by the Department of Health. The physician who is to perform the abortion, or his agent, must receive a copy of that written certification before performing the abortion.

Under the Unborn Child Pain Awareness and Prevention Act, the woman also must certify in writing prior to the abortion that the required information was provided to her on her right to see the government sponsored materials on fetuses and pain. This certification must be retained in the woman's medical file for three years.

Ark. Code Ann. §20-16-602.

Confirmation

Before the physician performs the abortion, he must also confirm that the patient has received information regarding (a) the medical risks associated with the particular method the physician is to employ; (b) the fetus's probable gestational age at the time of the abortion; (c) the medical risks associated with carrying the fetus to term; and (d) that a spouse, boyfriend, parent, friend, or other person cannot force her to have an abortion.

Ark. Code Ann. §20-16-903(b), as amended by Act 1605 of 2007 and Act 952 of 2009.

Pain Prevention Requirements

Under the Unborn Child Pain Awareness and Prevention Act of 2005, except in cases of medical emergency, before an abortion is performed of a fetus with a probable gestational age of 20 weeks or more, the physician or his agent must inform the woman: (1) whether an anesthetic or analgesic would eliminate or alleviate "organic pain" to the fetus and (2) of the risks associated with the particular anesthetic or analgesic. If the woman consents to the administration of an anesthetic or analgesic, the physician must administer it.

Ark. Code Ann. §20-16-1104.

Medical Emergency. In the case of a medical emergency, the physician must inform the patient, before performing the abortion if possible, of the medical reasons that the physician deems abortion necessary either (a) to prevent the patient's death; or (b) to prevent substantial and irreversible impairment of a major bodily function. A "medical emergency" is defined as any condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate termination of pregnancy to avert her death or for which a delay will create serious risk of impairment of a major bodily function that is substantial and deemed to be irreversible. A physician who seeks to perform an emergency abortion without following the provisions of the Unborn Child Pain Awareness and Prevention Act also, if possible, must inform the patient prior to the abortion "of the medical indications supporting the physician's judgment" that an abortion is necessary to prevent her death or that a 24-hour delay will create a serious risk of substantial and irreversible impairment of a major bodily function.

Ark. Code Ann. §20-16-1107.

Penalties.

Discipline. A person who knowingly or recklessly performs or attempts to perform an abortion in violation of these laws is subject to discipline by the Arkansas State Medical Board.

The woman upon whom the abortion has been performed or attempted to be performed is not subject to any penalty under this code section.
Ark. Code. Ann. §20-16-704; 20-16-907; 20-16-1109.

Civil lawsuit for monetary damages. A physician who knowingly or recklessly violates the Unborn Child Pain Awareness and Prevention Act may be sued for "actual and punitive" damages by the woman who had the abortion, or by the father or by a grandparent of the aborted fetus. Any woman upon whom an abortion was attempted in violation of the Act may also file suit. "Attempt to perform an abortion" is defined as an act or omission of a statutorily required act, that under the circumstances as the actor believed them to be, constitutes a substantial step in a course of conduct planned to culminate in the termination of a pregnancy in Arkansas.

The statute gives the court the power to award attorneys' fees against the physician if he loses the case. The physician may be awarded his legal fees if the lawsuit against him was "frivolous and brought in bad faith."
Ark. Code Ann. §§20-16-1110, 20-16-1102(2).

Mandatory Reporting

Reporting requirements on physicians who perform abortions are mandatory. By February 28th of each year, each physician who provided or whose employee provided information pertaining to fetal pain during abortions to females during the previous year must submit to the Department of Health a copy of the form distributed by the Department of Health. The form must have the information requested entered accurately and completely. The Department of Health may access a fee of $500 against physicians who fail to submit a report within thirty days after the due date. An additional $500 fee will be accessed for each additional thirty day period during which the report is overdue. If the physician has not submitted the report more than one year following the due date, the Department may seek an order requiring the physician to submit the complete report within a period established by the court. Failure to file the complete report within the court-ordered period will result in civil contempt.
Ark. Code Ann. §20-16-1108.

See Reporting, Mandatory, Abortions at page 216.

Ark. Code Ann. § 20-16-901 and following, as amended by Act 1605 of 2007, Act 952 of 2009; Arkansas State Medical Board Reg. 26, adopted June 7, 2002; Ark. Code Ann. §20-16-1101 and following.

Parental Consent Requirements

A physician contemplating performing an abortion on an unemancipated minor or an incompetent woman for whom a guardian or custodian has been appointed, must have written consent from a parent or from the legal guardian or custodian. Either parent may give the written consent. An "**unemancipated minor**" means a person under the age of 18 years who is under the care, custody, and control of her parents.

Written consent must include, at a minimum: the name and birth date of the minor or incompetent woman; the name of the parent or legal guardian; a statement from the parent or guardian expressing awareness of the minor's desire for an abortion and consenting to the abortion; the date, and the notarized signature of the parent or guardian. However, a notarized signature is not required if the physician or physician's agent witnesses the signature of the

parent or legal guardian, signs the written consent as a witness, and obtains positive proof of identification from the parent or guardian in the form of a valid photo identification card prior to signing the consent as a witness. A photocopy of the proof of identification and the written consent statement must be kept in the minor's or incompetent woman's medical records for five years from the date of the abortion.

This Guide expresses no opinion on whether this language is pre-emped by the federal Health Insurance Portability and Accountability Act. Practitioners with any questions on this issue should consult legal counsel.

Ark. Code Ann. § 20-16-801 to 803.

Judicial Bypass of Parental Consent

The unemancipated minor or incompetent woman may substitute judicial authorization for parental or guardian consent, in a confidential hearing, at no cost to her. After a hearing in circuit court, the judge must authorize a physician to perform the abortion if the judge determines the pregnant minor or incompetent woman is "mature and capable of giving informed consent" to the abortion. If the judge finds that the minor or incompetent woman is not mature, then the judge must determine whether an abortion, without parental consent, would be in the woman's best interest. If so, the judge must authorize performing the abortion without consent. While a record must be made of the judge's factual findings and legal conclusions, all court records are sealed.

The court will inform the pregnant minor or incompetent woman that she has the right to have a lawyer represent her, and will appoint a lawyer for her if she so chooses. The proceeding will be expedited so that the judge may reach a decision quickly. The pregnant minor or incompetent woman also has the right to an expedited, confidential appeal if the judge denies authorization of abortion without consent.

Ark. Code Ann. §20-16-804.

Exceptions to Consent Requirement

Parental or judicial consent is not required under some circumstances: (1) a medical emergency in which the attending physician certifies in the medical record that there is insufficient time to obtain the required written consent and there is a medical emergency, as defined below; (2) both of the parents' whereabouts are unknown; (3) the minor has only one living parent and the minor states by affidavit that the living parent has committed incest with the minor, raped the minor, or otherwise sexually abused the minor; or (4) the guardianship or custody order has expired or is no longer in effect. For purposes of consent, a medical emergency means a "condition that, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function."

Ark. Code Ann. §§20-16-804; 20-16-808, as amended by Act 758 of 2009.

Penalty

A physician who violates the consent provision is guilty of a Class A misdemeanor and is liable in a civil action by the person whose consent is required.

Ark. Code Ann. §§ 20-16-806, as amended by Act 758 of 2009.

Reporting

A physician who provides abortions must report certain information with each abortion. In addition to other information reported to the Department of Health, a physician must report whether parental consent was required and obtained or whether a judicial bypass was obtained. If a minor does not have to obtain consent because she submits an affidavit stating that her parent committed incest with her, raped her or sexually abused her, the attending physician must report the abuse as provided under the child maltreatment laws.
Ark. Code Ann. § 20-16-810.

See Mandatory Physician Reporting, Child Maltreatment at page 219.

Vital Record Requirements

Reporting Termination of Pregnancy

Induced abortions, regardless of the length of gestation, must be reported within five days to the Division of Vital Records by the person in charge of the institution. If the abortion was performed outside an institution, then the attending physician must prepare and file the report. These reports are used only for medical and health purposes. The report must not identify the woman by name or by any other personal information.

Delivery of Dead Fetus

Fetal death must be reported to the Division of Vital Records within five days after delivery of a dead fetus when the fetus weighs 350 grams or more, or if the fetus's weight is unknown, then only if the fetus completed 20 weeks gestation or more. There are three different reporting situations: (1) when fetal death occurs in an institution, the institution's director or his representative must prepare and file the fetal death certificate; (2) when a dead fetus is delivered outside an institution, the attending physician must prepare and file the fetal death certificate; (3) when a fetal death occurs without medical attendance at or immediately after delivery, or is subject to inquiry as required by law, then the medical examiner or coroner must investigate the cause of the fetal death and must prepare and file the report within five days.

Spontaneous fetal deaths where the fetus completed less than 20 weeks gestation and weighed less than 350 grams must be reported following the same procedure as reporting an induced abortion.
Ark. Code Ann. § 20-18-603.

Family Planning Act

The Family Planning Act was adopted for the purpose of ensuring ready legal access to contraceptive procedures, supplies and information for those who desire them. The State has asserted a public interest in controlling population growth when it leads to social, economic, and environmental problems.

The State's policy is to ensure, to anyone who desires them, the availability of contraceptive procedures, supplies, and information regardless of the person's sex, race, age, income, number of children, marital status, citizenship, or motive. Permanent sterilization is consistent with public policy when it is performed by a physician on a consenting adult or legally married minor.

Medically acceptable contraceptive information may be disseminated in state and county health and welfare departments, in medical facilities, at schools of higher learning, and at other agencies of this state.

Notwithstanding the above, physicians, pharmacists or other "authorized paramedical personnel", private institutions, physicians' employees, and employees of a public institution acting under direction of a physician may refuse to provide contraceptive procedures, supplies, or information when the refusal is based on religious or conscientious objections.
Ark. Code Ann. §§ 20-16-301 to 304.

Liability for Sterilization

Subject to the general law on negligence, no physician licensed in Arkansas can be held liable civilly or criminally by reason of having performed surgical sterilization (authorized under the Arkansas Family Planning Act) on a person in this state.
Ark. Code Ann. § 20-16-305.

FORMS, COMPLETION OF

Attending physicians should complete without charge the appropriate "simplified" insurance claim form as part of the service to the patient to enable the patient to obtain benefits, according to AMA Code of Medical Ethics §6.07. The rule states that a charge for more complex or multiple forms may be made in conformity with local custom.

Medicaid recipients may not be billed by physicians for completion and submission of a Medicaid Claim form, Arkansas *Medicaid Physician Provider Manual §§ I-131.000 (Rev. 09/2008),* *at* https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/physicn.aspx#manual.

As far as charging for filling out forms for patients and their employers under the federal Family Medical Leave Act, while there appears to be no prohibition against charging a fee for filling out such forms, any fees charged should be reasonable and mindful of the patient's circumstances.

Worker's Compensation law does prohibit physicians from charging patients fees, over and above those paid by Workers' Compensation, for filing out forms required by the Arkansas Workers' Compensation Commission in connection with an injured worker's claim. See Arkansas Workers' Compensation Commission Rule 99.30(I)(N)(5) at http://www.awcc.state.ar.us/ruleind.html

FRAUD AND ABUSE

Federal Criminal Provisions

The government has a vast arsenal of criminal laws it can call on to combat fraud and abuse. Some of the more important laws follow.

Antikickback Act

Anyone who knowingly and willfully solicits or receives, or pays or offers, anything of value to induce, or in return for, referral of patients or services covered by a federal health care program will be guilty of a felony, and on conviction will be fined up to $25,000 or imprisoned

for not more than five years, or both. In addition, the government can impose administrative sanctions ("civil monetary penalties") consisting of a fine of $50,000, treble damages and exclusion from federal health care programs. Numerous arrangements can be implicated by the Antikickback Act, particularly those involving joint ventures between physicians and hospitals or even everyday arrangements between providers such as lease agreements, consulting contracts, hospital perks, etc. However, the federal Department of Health and Human Services has promulgated a number of "safe harbors." If an arrangement is structured in accordance with a safe harbor, then the provider will not be prosecuted. If an arrangement does not meet the safe harbor criteria, it does not necessarily mean the arrangement is illegal, but it does mean there are no assurances of protection. There are very specific criteria for each safe harbor, but the guiding principle is that arrangements with providers who serve Medicare or Medicaid patients must be based on fair market value, not the volume or value of referrals.
42 U.S.C. § 1320a-7b(b); 42 U.S.C. 1320a-7a.

Federal Health Care Program Fraud

Federal law prohibits health care providers from making misrepresentations about the services they render to patients in Medicare and Medicaid or other government programs. Providers are guilty of fraud when they (1) knowingly and willfully make or cause to be made any false statement or representation of a material fact in seeking to obtain payment; (2) fraudulently conceal or fail to disclose information affecting one's right to a payment; (3) convert any benefit or payment rightfully belonging to another person; (4) present or cause to be presented a claim for a physician service knowing that the person who furnished the service was not licensed as a physician; (5) knowingly and willfully make false statements to qualify an institution or facility for participation; (6) knowingly and willfully overcharge or seek supplemental payments from Medicaid; or (7) knowingly, willfully, and repeatedly violate assignment or agreement to be a participating physician -under Medicare.

A provider who violates any of the first six sections of this law commits a felony and may be fined up to $25,000, or imprisoned for up to five years, or both. A conviction under (7) is a misdemeanor punishable by a fine of up to $2,000, or imprisonment for up to six months, or both.
42 U.S.C. § 1320a-7b(a),(c)-(e).

Other Federal Criminal Law

Congress amended the U.S. Criminal Code so that a number of existing sections now apply to crimes involving health benefit programs. Congress also added a number of sections dealing specifically with crimes involving health benefit programs, including theft or embezzlement, forfeiture, false statements, fraud, obstruction of criminal investigations, and so on. 18 U.S.C. § 1347 now makes it a crime to knowingly and willfully defraud any health care program, including *private* plans.
18 U.S.C. § 287, 371, 664, 669, 699, 982, 1001, 1027, 1035, 1341, 1343, 1345, 1347, 1518, 1954, 1956, 3486.

Arkansas Criminal Laws

Medicaid Fraud Act

Arkansas's fraud and abuse laws focus on Medicaid because it is a partially state funded program, as opposed to Medicare, which is entirely federally funded. Like its federal counterpart,

Arkansas' law criminalizes purposefully (1) making or causing to be made any false statement or representation of a material fact in an application for payment or benefits or for use in determining rights to such payment or benefit; (2) concealing or failing to disclose facts affecting rights to benefit or payment; (3) converting a benefit or payment belonging to another person to a wrongful use; (4) presenting or causing to be presented a claim for a physician's service while knowing that the individual who furnished the service was not a licensed physician; and (5) soliciting or receiving, or offering or paying, any remuneration, including any kickback, bribe or rebate, directly or indirectly, overtly or covertly, in cash or in kind for referral of a patient covered by Medicaid or for purchasing, leasing, ordering, arranging for or recommending any facility, service or item covered by Medicaid (with exceptions similar to the federal "safe harbors"); (6) making false statements or representations in order to qualify a facility for Medicaid or Medicare participation; (7) charging a Medicaid patient in excess of the state-approved limit; or (8) soliciting or receiving any donation or other amount over and above the Medicaid payment.

Persons found guilty of Medicaid fraud are subject to a mandatory fine of up to $3,000 for each claim, damages of three times the amount illegally received, plus a prison sentence as provided under Arkansas law, which varies depending on the amount illegally obtained. If a provider is convicted of Medicaid fraud, then the provider will be prevented from further participation in the Arkansas Medicaid program. If a provider is found guilty of or has pled guilty to the charge of Medicaid fraud, theft of public benefits, or abuse of adults, and the provider participates, directly or indirectly in the Arkansas Medicaid program, then the provider will be denied further participation.
Ark. Code Ann. § 5-55-101 to 114, as amended by Act 827 of 2007.

Whistleblowers

The courts are authorized to reward persons who provided information "which led to the detecting and bringing to trial and punishment persons guilty of violating the Medicaid fraud laws." The person may receive 10 percent of the aggregate penalty recovered, up to $100,000.
Ark. Code Ann. § 5-55-113.

Federal Civil Provisions

If the government lacks the more demanding proof required for criminal laws, it often resorts to civil statutes.

Civil False Claims Act

In recent years, the government has become increasingly aggressive in its use of the civil False Claims Act. A "claim" may be a single CPT code or an entire claim form, depending on the court's interpretation. The Act makes it illegal to "knowingly" submit false claims, which includes "reckless disregard" for the truth or falsity of the claims submitted. If found liable, the provider must pay penalties of $5,500 to $11,000 per claim and treble damages (triple the amount of false claims). The more lenient standard for liability (actual knowledge, deliberate ignorance of the truth, or "reckless disregard" of the truth) and the stiffer penalties and damages has generally made the False Claims Act more attractive to prosecutors than the Civil Monetary Penalties Law. A section of the False Claims Act known as *"qui tam"* provides that "whistleblowers" who bring the wrongdoing to the attention of the government may obtain 15 to 30 percent of the total recovery. *31 U.S.C. § 3729 to 3731.*

Civil Monetary Penalties Law

The Secretary of Health and Human Services has the authority to administratively impose sanctions for a wide array of activities under this law. Civil monetary penalties may be imposed on:

1. Any person or entity who presents a claim for a medical item or service that: (a) the person or entity knows or has reason to know was not provided as claimed, or is false or fraudulent; (b) is for a physician's service that the presenter knows or has reason to know was furnished or supervised by a person not licensed as a physician, or who obtained his or her license through misrepresentation, or falsely represented to the patient that he or she was board certified; (c) is furnished during a period in which the person was excluded from participation or had his or her provider agreement terminated; or (d) is not medically necessary. Violations carry a civil monetary penalty of up to $10,000 for each item or service plus an assessment of up to three times the amount claimed for each item or service. *42 U.S.C. § 1320a-7a(a)(1).*
2. Any person or entity who requests payment in violation of the terms of Medicare assignment, an agreement with a state Medicaid agency not to charge in excess of a prescribed amount, or an agreement to be a participating physician or supplier. Sanctions include a penalty of up to $10,000 for each item or service plus treble damages. *§1320a-7a(a)(2).*
3. Any person who gives information that he knows or has reason to know is false or misleading and that could reasonably be expected to influence a decision when to discharge a Medicare hospital inpatient. Maximum penalty of $15,000 for each beneficiary with respect to whom such information was given, plus treble damages. *§ 1320a-7a(a)(3).*
4. Any entity that knowingly retains an individual as an owner, officer or manager when the entity knows or should know that the individual has been excluded from Medicare or Medicaid. *§ 1320a-7a(a)(4).* Carries a maximum penalty of $10,000 per day, plus treble damages.
5. Any person or entity who pays or offers to pay a beneficiary anything of value to obtain the beneficiary's business under Medicare or Medicaid. Penalty of up to $10,000 per day, plus treble damages. *§ 1320a-7a(a)(5).*
6. Any person who knowingly contracts with a person or entity that has been excluded from Medicare or Medicaid. Penalty of up to $10,000 per day, plus treble damages. *§ 1320a-7a(a)(6).*
7. Any person or entity who engages in an activity that the Secretary believes would constitute a violation of the Antikickback Act. $50,000 penalty for each act, plus treble damages. *§ 1320a-7a(a)(7).*
8. If a hospital knowingly makes a payment to a physician as an inducement to reduce or limit services provided to Medicare or Medicaid beneficiaries, the organization is subject, in addition to other penalties prescribed by law, to a civil monetary penalty of up to $2,000 for each beneficiary with respect to whom the payment is made. A physician accepting such payment is also subject to a penalty of up to $2,000 for each beneficiary. *§ 1320a-7a(b).*
9. Physicians *not* participating in Medicare (i.e. not accepting assignment) are subject to civil monetary penalties under a number of provisions. They may be penalized or

excluded for knowingly and willfully failing to refund any amount collected from a beneficiary if the services are later determined by a carrier or peer review organization to be non-reimbursable, or for failure to use an "Advance Beneficiary Notice" when it was reasonable to expect that Medicare would not pay for the service. In addition, they may be penalized or suspended for knowingly and willfully billing a charge in excess of the maximum allowable charge for non-participating physicians, i.e. up to 115% of the Medicare-approved rate. *42 U.S.C. § 1395u and CMS Pub. 100-04, Medicare Claims Processing Manual §30-140.12.*

Procedure

The Secretary of HHS may initiate an action for a civil monetary penalty up to six years after the claim is presented. The accused person is entitled to notice, and upon request, to an administrative hearing. The Secretary may consider aggravating and mitigating circumstances in determining the amount of the penalty. The secretary has also promulgated through regulations some additional bases for penalties.
42 Code of Federal Regulations § 402 and § 1003.

Exclusion

In addition to the previously mentioned penalties, HHS has the authority to exclude providers from participating in the Medicare and Medicaid programs. Certain offenses (certain felonies and any offense related to the delivery of health care services) trigger "mandatory exclusions" for at least five years. Various other offenses, including violations of the civil False Claims Act, may trigger "permissive exclusion," in the Secretary's discretion, for at least three years.
42 U.S.C. § 1320a-7; 42 Code of Federal Regulations §§ 1001.101 to 1001.1701.

Stark: Physician Self-Referral Restrictions

The complex Stark law, *42 U.S.C. § 1395nn* (named for Rep. Pete Stark of California), prohibits physicians from making referrals of certain services to businesses (including their own clinics) in which they have a financial relationship. More specifically, the law states that if a physician (or an immediate family member) has a "financial relationship" with an entity, then the physician may not refer a Medicare or Medicaid patient to the entity for "designated health services." The two key terms here are "financial relationships" and "designated health services."

"Financial relationship" is extremely broad and includes two general categories: (1) An *ownership or investment interest* through equity, debt or other means; and (2) a *compensation arrangement* between the physician and the entity, meaning any salary or other remuneration, direct or indirect, in cash or in kind.

Stark covers the following "designated health services":

1. Clinical laboratory services;
2. Physical, occupational, and speech therapy;
3. Radiology and certain other imaging services, including MRI, CAT, ultrasound;
4. Radiation therapy services and supplies;
5. Durable medical equipment and supplies;
6. Parenteral and enteral nutrients, equipment and supplies;
7. Prosthetics, orthotics, and prosthetics devices and supplies;

8. Home health services;
9. Outpatient prescription drugs; and
10. Inpatient and outpatient hospital services.

Sanctions for violation of Stark can include: refunds; a civil penalty of $15,000 for each improper claim that a person "knows or should know" is a violation; a civil penalty of $100,000 for engaging in more elaborate circumvention schemes (such as cross-referral arrangement), and exclusion from Medicare and Medicaid.

The guiding principle to keep in mind is that under Stark, if a physician (or an immediate family member) has a financial relationship with an entity, the physician may not make a referral to the entity for Medicare or Medicaid services, and the entity may not make a claim to Medicare or Medicaid or bill anyone else for the service. If a violation occurs, the payment must be refunded — the intent of the parties is irrelevant in this regard. This is one of the primary distinctions between Stark and the Antikickback Act. Under the Antikickback Act, the government must prove that the provider in question offered, paid, solicited or received remuneration with the intent of inducing referrals. With Stark, the government no longer has to overcome the obstacle of proving intent in order for a violation to occur that will require repayment. However, in order to impose the monetary penalties under Stark, the government does have to prove that a person "knew or should have known" that his action would violate the statute.

A physician's referrals to an entity with which he/she has a financial relationship are flatly prohibited under Stark, unless an exception applies. The exceptions are in three categories: (1) exceptions related to both ownership/investment and compensation arrangements; (2) exceptions related only to ownership or investment interests; and (3) exceptions related only to compensation arrangements.

Group Practice. Physicians can more easily fit within certain exceptions if they meet the definition of a true group practice. The statute defines "group practice" as follows:

1. Single legal entity.
2. At least two physicians who are "members" (owners or employees, not independent contractors).
3. Each member of the group must furnish through the group "substantially the full range" of his or her patient care services.
4. "Substantially all" (at least 75%) of patient care services provided by member physicians must be provided through the group.
5. The overhead expenses and income from the group must be distributed according to methods that are determined before receipt of payment for the services.
6. The overhead expenses and income must be distributed according to methods that indicate that the practice is a "unified business," i.e., (a) centralized decision making, and (b) consolidated billing, accounting and financial reporting (although some cost-center or location-based compensation practices are allowed).
7. No member of the group directly or indirectly receives compensation based on the volume or value of referrals, except under the special rule for profits shares and productivity bonuses.
8. The members of the group practice personally conduct at least 75% of the physician-patient encounters of the group practice.

Special Rule for Productivity. The group practice definition prohibits basing compensation on the volume or value of referrals. For example, the group cannot have a system in which revenues from the group's X-ray or clinical lab are paid out to each physician based on the number of tests he or she ordered. However, personally performed services are not considered referrals. Thus, a special provision allows for compensation based on "profits and productivity bonuses": "A physician in a group practice may be paid a share of *overall profits* of the group, or a *productivity bonus* based on services personally performed . . . so long as the share or bonus is not determined in any manner which is directly related to the volume or value of referrals by such physician." This means that physicians may be directly compensated for their personally performed designated health services and services "incident to" those personally performed services. "Incident to" is a term of art in the Medicare regulations, defined at 42 *Code of Federal Regulations* § 410.26(b) and the *CMS Pub. 100-02 Medicare Benefit Policy Manual at § 15-60.1*. Physicians still may not be directly compensated for referrals of services performed by someone else in the group; the group will have to distribute the income based on an indirect method not tied to referrals.

Listed below are some of the more important exceptions to the prohibitions in Stark.

Exceptions to Both Ownership/Investment and Compensation Arrangements

In-office ancillary services. This is one of the most important exceptions. To legally refer Medicare/Medicaid patients to one's own in-house ancillary services one must meet all three of the following requirements:

1. The "provider supervision test" - The designated health services must be furnished personally by one of the following individuals: (a) the referring physician; (b) a physician who is a member of the same group practice as the referring physician; or (c) an individual who is supervised by the referring physician or another physician in the group practice.
2. The "location test" - It requires that the designated health services must be furnished either (a) in the *same building* in which the referring physician or another physician who is a member of the same group furnishes routine non-designated health services; or (b) a separate *centralized location(s)* for designated health services furnished by a group practice.
3. The "billing test" - The designated health services must be billed by (a) the physician performing or supervising the services; (b) the group practice under the group's billing number; (c) an entity that is wholly owned by the physician or group; or (d) a billing agent.

Exceptions Related Only to Ownership/Investment Interests

Publicly traded securities and mutual funds. Stark allows ownership of investment securities involving designated health services if they are purchased on terms generally available to the public, publicly listed or traded, and in a corporation that has stockholder equity exceeding $75 million (or in an investment company with assets exceeding $75 million).

Rural provider. Stark allows a physician to invest in an entity providing designated health services in a rural area (outside a Standard Metropolitan Statistical Area) if "substantially all" (not less than 75%) of the designated health services are furnished to individuals residing in the rural area.

Hospital ownership. Stark allows a physician to refer patients in need of designated health services to a hospital in which the physician has invested if (1) the referring physician is authorized to perform services at the hospital, and (2) the physician's interest is in the hospital itself and not merely in a subdivision of the hospital.

Exceptions Relating Only to Compensation Arrangements

Rental of office space. This provision is similar to a safe harbor in the Antikickback Act. It is designed to keep health care providers who are landlords and tenants from working out special deals that unnecessarily drive up utilization. For example, Stark would prohibit an arrangement in which a hospital landlord gives physician tenants free or discounted office space and in return the physicians send their patients to the hospital. For one provider to refer Medicare or Medicaid patients to the other in a landlord-tenant situation, the parties must meet the following requirements:

1. The lease is set out in writing, signed by the parties, and specifies the premises it covers.
2. The lease is for a term of at least one year.
3. The space rented or leased is not more than what is reasonably necessary for the lessee's legitimate business purposes, and is used exclusively by the lessee when being used by the lessee.
4. The rental charges are set in advance and consistent with fair market value.
5. The charges are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.
6. The lease would be commercially reasonable even if no referrals were made between the parties.
7. The lease may have month-to-month holdovers of up to six months immediately following termination after 1 year, if the holdovers are on the same terms and conditions.

Rental of equipment. The same type of requirements for rental of office space apply to the exception on renting equipment.

Bona fide employment relationships. Basically, this exception allows an employer to pay physicians a salary as long as it is consistent with fair market value and not based on the volume or value of any referrals. Without this exception, if a physician referred patients for ancillary services to the clinic where he or she was employed, technically this would be a violation of Stark since the salary would constitute "compensation." Basing salary or bonuses on productivity is not prohibited if structured properly.

Personal services arrangements. This exception covers independent contractor and other contractual relations that fall short of bona fide employment. Essentially it allows a physician to make referrals to entities from which the physician receives payments for services if the financial arrangement meets certain requirements, *e.g.,* is set out in writing, is for a term of at least one year, covers all the services to be provided, the services do not exceed those reasonably necessary, and the compensation is set at fair market value.

Physician incentive plan. This exception allows managed care companies to pay physicians

through withholds, capitation, bonuses, etc., to promote utilization control without the compensation being construed as a financial compensation under Stark.

Physician recruitment. Payments made by hospitals to recruit physicians are acceptable in certain situations.

Isolated Transactions. This exception allows isolated financial transactions, such as a one-time sale of a physician's practice to another provider, if certain requirements are met.

Medical Staff Incidental Benefits. Allows hospitals to provide incidental gifts and other benefits of low value (less than $25 each) to staff physicians.

Only the major or most common exceptions have been listed. This is a general overview of Stark, and physicians need to contact an attorney if they are involved in an arrangement involving designated health services.

Arkansas Civil Laws

Civil Medicaid Fraud False Claims Act

This law provides civil sanctions for the same types of conduct constituting criminal fraud under the Arkansas Medicaid Fraud Act, *Ark. Code Ann. § 5-55-111.* It is likely to be used when the government cannot meet the higher burden of proof required for a criminal conviction. Persons found liable under this act are required to pay full restitution, three times the amount of fraudulently received payments, plus a civil penalty of $5,000 to $10,000 for each violation. If the person voluntarily comes forward under certain circumstances, the damages will be reduced to twice the amount of illegal payments. The state can bring suit up to five years after a violation occurs.

Ark. Code Ann. § 20-77-901 to 911.

Arkansas Medicaid Integrity Law

These are *administrative* sanctions, in addition to the sanctions in the criminal Medicaid Fraud Act and those in the civil Medicaid Fraud False Claims Act. The stated purpose of this 1999 law is to protect the Medicaid program against health care providers who attempt to obtain payments to which they are not entitled. The Director of the Department of Human Services is authorized to set up a procedure to review claims by health care providers to determine if the claims should be or should have been paid as required by federal or state law or rule. The review may come before or after payment is made to a health care provider. The Director can withhold payment to a health care provider during a claim review if "necessary to protect the fiscal integrity of the medical assistance programs." However, the health care provider must have an opportunity for a hearing within sixty days of the date payment is withheld. The Director also is authorized to impose recoupment, liquidated damages, and/or exclusion from Medicaid. A health care provider who receives an administrative sanction may request a hearing to contest the sanction, and if not cleared, the person may seek judicial review.

Ark. Code Ann. §§ 20-77-1301 to 1305.

Fee Splitting

Fee splitting can take many forms. It exists when a physician receives any type of

remuneration for referring business to another person or entity. These practices are unethical. A physician may not accept payment of any kind, in any form, from any source for prescribing a drug or product, or referring a patient. All referrals must be based on the skill and quality of the physician to whom the patients have been referred or the quality and efficacy of the drug or product prescribed.
AMA Code of Medical Ethics, § 6.02.

Likewise, health care facilities should not compensate physicians who refer patients to the health care facility where the physician then performs such services as prescribing, monitoring, or revising the patient's course of treatment. Payment for these services may be made by either the patient who benefits from the services or the patient's insurance carrier. It is also unethical to accept payment for referring patients to research studies.
AMA Code of Medical Ethics, §6.03.

Physicians are also not permitted to accept payments from pharmaceutical companies or device manufacturers in exchange for prescribing their products. Drugs or devices must be prescribed based on reasonable expectations of effectiveness for the particular patient. The quantity of the drug prescribed should be no greater than that which is reasonably required for the patient's condition.
AMA Code of Medical Ethics, §8.06.

Health Care Integrity and Protection Data Bank

A nationwide data bank has been created that is designed to collect and disclose information about health care practitioners who have committed fraud and abuse. The data bank, titled the Health care Integrity and Protection Data Bank (HIPDB), collects information on, among other things, final adverse actions against physicians, other health care practitioners, providers and suppliers. "Final adverse action" means criminal convictions and civil judgments in connection with the delivery of a health-related service or item; exclusion from participation in federal or state health care programs; negative actions or findings by agencies responsible for licensing and certification including, but not limited to, suspension, revocation, reprimand, probation or limitations on the scope of practice. The information in the HIPDB is not intended to be duplicative of the reporting requirements for the National Practitioner Data Bank.

The reporting requirements went into effect November 22, 1999. Certain entities, including health plans, are now required by law to make the reports to the data bank either within 30 calendar days from the date the final adverse action was taken or the date when the reporting entity became aware of the final adverse action or by the close of the entity's next monthly reporting cycle, whichever is later. "Health plans" includes traditional health insurers, HMOs, and other health benefit plans. If a health plan fails to make the required report, it may be forced to pay a civil monetary penalty of up to $25,000 per each action not reported. No such penalty will be imposed against government entities that fail to make the required reports.

Who Must Report

Federal and state government agencies are responsible for reporting health care practitioners, providers or suppliers who are excluded from participation in federal or state health care programs, including exclusions made in an unreported settlement that does not contain findings or admissions of liability. The report must be made regardless of whether there is a pending appeal of the exclusion.

Federal and state attorneys and health plans must report civil judgments against practitioners,

providers or suppliers related to the delivery of a health care item or service, regardless of whether the judgment is being appealed.

Federal and state prosecutors must report criminal convictions of practitioners, providers and suppliers related to the delivery of a health care service or item, regardless of whether the conviction is being appealed.

Federal and state agencies and health plans must report "final adverse actions" as well as "other adjudicated" decisions or actions against practitioners, providers or suppliers taken by a federal or state governmental agency or by a health plan related to the delivery, payment or provision of a health care item or service, regardless of whether the action is being appealed. "Other adjudicated" decisions or actions are defined at length at 45 *Code of Federal Regulations § 61.3.*

Federal and state licensing or certification agencies must report, among other things, revocation or suspension of a license or certification agreement or contract for participation in federal or state health care programs, regardless of whether the action has been appealed, and any other negative action or finding by federal or state agency that is publicly available information. See 45 *Code of Federal Regulations § 61.7* (Rev. June 17, 2009*).*

Correcting or Disputing a Report

Reporters who discover errors or omissions after the report is made must send the correction of addition to the HIPDB. The subject of any report will receive a copy of it, and may either accept the report as written or may provide a statement to the HIPDB, which will be permanently appended to the report and distributed with it.

The subject of a report may also dispute the accuracy of it, as long as it is done in writing within 60 calendar days from the date of receipt of the report. The dispute process is set out in detail at 45 *Code of Federal Regulations § 61.15.*

Who Has Access to the Information

Information from the HIPDB is available to federal and state government agencies, health plans, or to a health care practitioner, provider or supplier requesting information on himself, herself or itself. Statistical information that does not permit identification of any individual or entity is available as well. A fee may be charged for providing the information. Information reported to the HIPDB is considered confidential. Persons or entities receiving information from the HIPDB, either directly or from another party, must use it solely for the purpose for which it was provided. The HIPDB, individuals, entities and their authorized agents have immunity from civil suit filed by the subject of a report unless they made the report with "actual knowledge of the falsity" of the information in the report.

42 U.S.C. § 1320a-7e; 45 Code of Federal Regulations §§ 61 through 61.16.

See also National Practitioners Data Bank at page 198.

FREEDOM OF INFORMATION ACT

General Provisions

Unless a public record falls within an exception to the Freedom of Information Act (FOIA),

all public records must be made available for inspection and copying by citizens of Arkansas during the regular business hours of the custodian of the records. The partial list below represents some of the records that are not considered "public" and therefore do not need to be disclosed: (1) medical records, scholastic records, and adoption records; (2) unpublished drafts of judicial or quasi-judicial opinions and decisions; (3) undisclosed investigations by law enforcement agencies of suspected criminal activity; (4) documents that are protected from disclosure by court order; (5) personnel records, but only to the extent that disclosure would amount to a "clearly unwarranted invasion of personal privacy"; (6) state income tax records; (7) home addresses of non-elected state, city and county employees; (8) military service discharge records, and (9) records and executive sessions on security for any public water system.

If a public record is either in active use or in storage at the time of the request, the custodian must certify this fact in writing to the requestor and must set a date and time within three working days for the requestor to have access to the record. "Public records" mean those records required by law to be kept and that are a record of the performance of official functions by a public official or employee, a governmental agency, or any agency funded in whole or part by public funds. Receipt of Medicare or Medicaid funds does not transform a private physician's office into an agency covered by the FOIA.

Employee Records

Once there has been a final resolution by a public body of a proceeding to suspend or terminate an employee, all records forming the basis of that decision, including job performance evaluations and preliminary notes, are subject to disclosure if the person requesting disclosure can show a "compelling public interest" in their disclosure. However, an employee or his representative is always entitled to his own records. On receiving a request for an employee's personnel records, the custodian must, within 24 hours of the request, determine if the records are exempt from disclosure and make efforts to provide notification of his determination to the requestor and the subject of the records if they are not the same person. Either the employee, the custodian or the requester may seek an opinion from the Attorney General as to whether release of the employee's records falls within the public interest description.
Ark. Code Ann. § 25-19-101 and following, as amended by Acts 268, 726, and 998 of 2007, Acts 440, 631 and 1291 of 2009.

See also, Credentialing Organizations at page 55; Peer Review at page 196.

FUTILE CARE

Physicians are not obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefiting their patients. Nor should they give treatments simply because their patients demand them. The concept of "futility," which cannot be meaningfully defined, should not be used to justify denial of treatment. Instead a denial of treatment should be justified by ethical principles and acceptable standards of care.
AMA Code of Medical Ethics, § 2.035.

GASTRIC BYPASS

By statute, no gastric bypass surgery may be performed unless the physician informs the patient, in writing, of the risks and complications of the procedure. The patient must sign the writing, indicating that he understands: (1) the surgery itself; (2) all known and documented future complications; (3) side effects that may result from vitamin deficiency and malnutrition; and (4) the requirements for an appropriate follow-up.
Ark. Code Ann. § 17-95-108.

The Arkansas State Medical Board has enacted Regulation 27, which more specifically sets out the requirements for informed consent for this kind of surgery. The regulation details the 33 surgical complications, four nutritional complications, four psychiatric complications, 22 other complications, and eight complications related to pregnancy that must be disclosed to the patient prior to surgery. Other information that must be provided to the patient before the surgery includes potential benefits, the alternatives to surgery, need for dietary changes, an exercise plan and potentially for counseling, the importance of proper nutrition, that there is no guarantee of weight loss or long-term weight management, that a lifetime of follow-up medical care will be required, and that complications from the surgery could cause death, more surgery or prolonged hospital stays.

The physician must have the patient sign an informed consent form that states he or she has been told the required information. The failure of a physician to inform a patient, prior to the surgery, of all the required information and obtain the patient's signature on a form acknowledging same violates the Arkansas Medical Practices Act and is a cause for discipline.
Ark. State Medical Board Reg. 27, amended Feb. 5, 2004.

GENETIC INFORMATION

Genetic Information Nondiscrimination Act of 2008 (GINA)

The federal Genetic Information Nondiscrimination Act of 2008 ("GINA"), affects health insurers and employers in relation to the use and misuse of genetic information. This federal law defines "genetic information" as information about an individual's genetic tests, genetic tests of family members of the individual, and the manifestation of a disease or disorder in family members of such individual.*Public Law 1010-233, codified at 42 U.S.C. § 2000ff.*

Insurance. Under Title I of GINA, a group health plans or health insurance issuers are prohibited from: (1) adjusting premiums or contribution amounts for a group on the basis of genetic information, (2) requesting or requiring an individual or family member of an individual to undergo a genetic test, or (3) requesting, requiring, or purchasing genetic information for underwriting purposes or with respect any individual prior to such individual's enrollment in connection with such enrollment. These prohibitions were effective with plan years beginning after May, 2009, and apply to group health plans of any size

There are three narrow exceptions to these prohibitions: (1) A health care professional who is providing health care services to an individual may request that the individual undergo a genetic

test. (2) A plan or issuer may obtain and use the results of a genetic test for payment. The GINA regulations incorporate the HIPAA definition of payment and also require that the plan request the minimum amount of information necessary, as that term is used in HIPAA. (3) A plan or issuer may request, but not require, genetic testing for research purposes that meet the requirements set out in the implementing regulations.

Employment. Under Title II of GINA, an employer may not obtain genetic information from employees, prospective employees, or family members of the employees. There are six exceptions to this requirement: (1) information receiving during casual conversations between employees and employers, (2) genetic testing services that are provided as part of a voluntary wellness program, (3) information received from an employee who is requesting leave under the Family and Medical Leave Act (FMLA), (4) genetic information acquired by an employer through published documents that are publicly and commercially available., (5) genetic monitoring of the effects of toxic substances in the workplace under certain conditions, and (6) requests by employers engaged in law enforcement or human remains identification in limited circumstances. Although there are exceptions to the prohibition against obtaining genetic information employees, there are no exceptions to the prohibition on the use of genetic information—employers may not use genetic information in making employment decisions under any circumstances.

See also HIPAA at page 115.

Arkansas Law on Genetic Information

Physicians who have questions about the interplay between federal law and Arkansas law on genetic information should consult legal counsel. Sometimes, federal law can pre-empt state law.

Employment. Arkansas law prohibits employers from seeking to obtain or use genetic tests or information for the purpose of "distinguishing between or discriminating against or restricting any right or benefit otherwise due or available to an employee or prospective employee." "**Genetic information**" means "information derived from the results of a genetic test," and does not include family history, results of a routine physical examination or test; results of a chemical, blood, or urine analysis; results of a test to determine drug use; results of an HIV test; or results of any other test "commonly accepted in clinical practice at the time it is ordered by the insurer."

"**Genetic test**" means a lab test of DNA, RNA or chromosomes of an individual for the purpose of identifying the presence or absence of inherited alterations in the DNA, RNA or chromosomes that cause a predisposition for a clinically recognized disease or disorder.

Violation of this provision is a misdemeanor punishable by a fine of up to $25,000, and violators may also be incarcerated for no longer than one year.
Ark. Code Ann. § 11-5-401 and following.

Disclosure. Those who maintain genetic information are protected under Arkansas law from compulsory disclosure in legal proceedings except under certain restrictive situations. Under state law, genetic information can be obtained in civil paternity actions to determine paternity, where the individual whose genetic information is requested is a party to a legal proceeding in which the genetic information is at issue, in law enforcement investigations or criminal trials, or in law enforcement investigations when an insurer reports fraud or other criminal activity.
Ark. Code Ann. § 16-43-1101.

Information from studies and other sources. State law provides that the records of individual subjects who participate in genetic research studies as defined by federal law may not be released except for limited reasons. These reasons include cases where the genetic information is the basis of a legal action, or where the person gives informed, written authorization for release of the information to employers or insurers.

Under state law, stored tissues and blood from surgery, other procedures or autopsy may be used for research purposes only if the donor's identifying information is not included with the specimen, or if the patient gives a separate informed written authorization for disclosure. Also under state law, individual subjects may only be identified in research publications if the individual gives informed written authorization to being identified.
Ark. Code Ann. § 20-35-101 and following

See also Genetic Nondiscrimination in Insurance Act at page 144.

GOVERNMENTAL TORT IMMUNITY ACT

Counties, municipal corporations, school districts, special improvement districts, and all other political divisions of the State of Arkansas possess immunity from liability and suit for damages under state law except for the amount covered by liability insurance. This immunity extends to agents and employees for actions in their official capacities. However, intentional illegal acts committed by agents and employees are not covered by this grant of immunity.
Ark. Code Ann. § 21-9-301.

See also, Tort Liability - Immunity at page 239.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) AS AMENDED IN 2009 BY HITECH

The Health Insurance Portability and Accountability Act of 1986 (HIPAA), which was significantly amended in 2009, was enacted for several purposes—to improve the portability of health insurance by allowing many people to keep insurance when they move from job to job or they experience other events such as the addition of a dependent, to combat fraud and abuse in the health care system, and to simplify the administration of the health care system. It is this last purpose with which most providers are concerned, because the law and accompanying regulations mandate how health care plans, providers, and clearinghouses store and transmit individuals' personal health care information.

The "Administrative Simplification" section of HIPAA contains rules related to **Privacy**, **Security,** and **Transactions and Code Sets**. These rules contain national standards for protecting the privacy and security of personal health information as well as for the transmission of that information to other entities as part of the billing or referral process. Your practice must comply with all three sets of these rules for individuals' health care information, whether that

information is stored in a paper format in a patient file or electronically in an electronic health record.

The economic stimulus package passed by Congress in early 2009 included **the Health Information Technology for Economic and Clinical Health Act (HITECH).** HITECH included provisions designed to promote the use of health care technology. HITECH made a number of significant changes to HIPAA that will affect providers, health plans, clearinghouses, and certain entities that do business with providers. Some of these provisions have already taken effect; others will take effect at future dates.

The Privacy Rule

The Administrative Simplification regulation entitled "Standards for Privacy of Individually Identifiable Health Information" is referred to as the **Privacy Rule**. It has been in effect since April 14, 2003. Many of the applications of the Privacy Rule are simply common sense precautions that have been followed by medical practices for years. Others are somewhat more complex and afford patients greater knowledge of the content of their medical record and how that content is used. The content is termed **"protected health information"** or **"PHI."** The Privacy Rule enables the patient to control the disclosure of protected health information to certain entities.

Covered Entities

Originally, the Privacy Rule applied only to **"covered entities."** A covered entity means a health plan or other payor (including government payors), a health care clearinghouse (such as an organization or billing service that converts health information into or out of standard format), or a *health care provider*, including physicians. Providers are covered by the rule only if they transmit health information in electronic form. However, if they transmit any health care information in electronic form, they are then required to comply in all respects, including with regard to paper records. All healthcare providers who are covered entities must use a unique National Provider Identifier or "NPI," which are assigned by the federal Department of Health and Human Services ("DHHS"). HITECH changed the law so that some provisions of the Privacy Rule also apply to Business Associates of Covered Entities. See Business Associates, below.

Protected Health Information

The Privacy Rule essentially controls the use and disclosure of **protected health information (PHI).** PHI, with few exceptions, means "individually identifiable health information" held or disclosed by a practice regardless of how it is communicated (e.g., electronically, verbally, or written).

The term **"individually identifiable health information"** in turn means any health information (including demographic information) that is collected from the patient or created or received by a health care provider or other covered entity or employer that (1) relates to the past, present or future physical or mental health or condition of an individual, or (2) the provisions of health care, or (3) the past, present, or future payment for the provision of health care, that could potentially identify an individual.

The Privacy Rule lists 18 items that could be used to identify a patient. They are:

- Name.

- Any address specification such as street, city, county, precinct, and zip code
- All dates except for the year including birth date, admission date, discharge date, date of death and all ages over 89
- Telephone number
- Fax number
- Electronic mail address
- Social Security number
- Medical record number
- Health plan beneficiary number
- Account number maintained by the health care provider
- Certificate or license number such as driver's license number
- Vehicle identifier and serial number including license plate number
- Medical device identifier and serial number such as pacemaker serial number
- Web site address
- Internet protocol (IP) address number
- Biometric identifier including finger and voice prints
- Full face photographic images and any comparable image, and
- Any other unique identifying number characteristic or code.

Patient Rights

Under the Privacy Rule, patients have the following rights with regard to their PHI:

• The right to authorize the use and disclosure for certain non-TPO purposes and the right to authorize use and disclosure of psychotherapy notes. **("TPO"** refers to the treatment, payment or health care operations of a practice, see below.)

• The right to receive a copy of the practice's Notice of Privacy Practices.

• The right to request restrictions on certain uses and disclosures of PHI. As of February 17, 2010, HITECH requires the covered entity to comply with a patient request's for restriction of use and disclosure under this section if: (1) the disclosure is to a health plan for the purpose of payment or health care operations (and is not for treatment purposes) and (2) the PHI pertains solely to a health care item or service that the patient paid for in full out of pocket.

• The right to request restrictions on how the practice communicates PHI to the patient.

• The right to inspect and copy PHI. Effective in February, 2010, under the HITECH Act, if the covered entity maintains an electronic health record, then the individual shall have the right to obtain a copy of their PHI in an electronic format. The covered entity may charge a fee that is no more than the practice's labor costs for producing the information.

• The right to request an amendment of PHI.

• The right to an accounting of the disclosures of PHI made by the covered entity for purposes other than TPO and not pursuant to a valid authorization.

• The right to complain about alleged violations to the practices and the federal DHHS.

The TPO Umbrella

Generally, under the Privacy Rule, health care providers have the right to use and disclose PHI about a patient in order to carry out the treatment, payment or health care operations (referred to as TPO) of that provider's practice.

T: Treatment means the provision, coordination or management of health care and related

services by one or more health care providers or the referral of a patient for health care from one provider to another. ***See Psychotherapy Notes, below.***

P: Payment means payment-related communications with insurers and other activities conducted by the practice to obtain reimbursement for health care services. This includes, among other, billing, claims management, collection activities, verification of insurance coverage, and precertification of services.

O: Health Care Operations means activities related to your practice's business and clinical management and general administrative duties. Your practice may also disclose PHI to other covered entities in regard to an individual patient with whom you both have a relationship if the purpose for the disclosure falls into a certain category that includes quality assurance, quality improvement, case management, training program, licensing, credentialing, certification, accreditation, and development of care protocols. (However, use or disclosure of psychotherapy notes is more restricted.) Covered entities may also use and disclose PHI in regard to all activities associated with the selling, merging, transferring or consolidation of medical practices and other covered entities. The HITECH Act requires regulations to be promulgated by no later than August 2010 to eliminate from the definition of "Health Care Operations" any activities that can be reasonably and efficiently conducted through the use of de-identified information or that should require a valid authorization for use or disclosure. The HITECH Act limits the extent to which marketing activities may be included under the definition of Health Care Operations, effective with contracts beginning in February 2010. HITECH also provides that fundraising is not considered a Health Care Operation as of February 17, 2010.

The right to use and disclose PHI, with the exception of psychotherapy notes, for TPO purposes is valid as long as the provider makes a good faith effort to obtain written acknowledgement from the patient that he/she has received a copy of the practice's Notice of Privacy Practices. (See "Notice of Privacy Practices and Acknowledgement" below.)

Psychotherapy notes. There are greater restrictions on use or disclosure of psychotherapy notes, which are defined as notes recorded by a mental health professional documenting or analyzing conversations during a counseling session that are separated from the rest of the patient's medical records. Psychotherapy notes do not include information on medications prescribed, test results, summaries of treatment plans and certain other information. An authorization must be obtained prior to use or disclosure of psychotherapy notes except in certain very limited circumstances detailed in the regulations. See 45 Code of Federal Regulations § 164.508(a)(2).

<u>The Minimum Necessary Standard</u>

The Privacy Rule requires medical practices to take reasonable steps to limit the use or disclosure of PHI to what is minimally necessary to accomplish the intended purpose. This is known as the "minimum necessary" standard. For example, a medical practice may limit access to medical records only to the physicians, nurses and other clinical personnel within the practice who need access to the records to provide clinical care. The minimum necessary standard is not meant to interfere with quality patient care, thus there are important exceptions. For instance, the minimum necessary standard does not apply to information requested for treatment of a patient. The Privacy Rule requires that all covered entities implement policies and procedures to ensure that the "minimum necessary" standard is properly applied.

The HITECH Act requires the DHHS Secretary to issue guidance by mid-August 2010 on

what constitutes "minimum necessary" for purposes of the Privacy Rule. In the meantime, the HITECH Act provides that PHI meets the "minimum necessary" standard if it is limited, to the extent practicable, to the town, state, and zip code of the patient and any dates, including birth date, admission date, discharge date, date of death and all ages over 89. The exception "to the extent practicable" leaves room to include other information in the determination of what is the "minimum necessary." Additional information should be included only if it is necessary for the purpose for which the PHI is used or disclosed. Once the DHHS Secretary issues guidance on what is "minimum necessary," physician practices should limit their use and disclosure of PHI to those elements included in the guidance.

Restrictions on Disclosure

Under certain circumstances, the Privacy Rule allows patients the right to request restriction(s) on uses or disclosures of their PHI for TPO. Patients must be informed of their rights to request such restriction to their records; however, the provider is not required to agree to the restriction, with the exception as noted above under "Patient Rights." If the provider agrees to a restriction, it must document the restriction and must abide by the restriction unless there is an emergency and the restricted PHI is necessary to provide emergency treatment. In an emergency, the health care provider providing treatment cannot disclose the restricted information beyond what is necessary for the emergency treatment situation.

However, a medical practice must honor requested restrictions in the way it communicates with patients. Specifically, the practice must allow patients to request that communications regarding PHI be delivered by alternate means (e.g., picked up in person rather than mailed) or in alternate locations (e.g., different addresses). The practice must accommodate reasonable requests for such confidential communications. However, the practice may require the patient to make such a request in writing and may condition the accommodation on information needed for payment arrangements, and an alternative address or other contact method. The practice may not condition the confidential communication on receiving an explanation from the patient as to the basis for such a request.

Notice of Privacy Practices and Acknowledgement

Providers with direct treatment relationships must provide the patient with the Notice of Privacy Practices for PHI and use best efforts to obtain the patient's written acknowledgement of receipt of the Notice.

A Notice of Privacy Practices is a document that health care providers and other covered entities must develop in order to inform patients about their rights surrounding the protection of their PHI. The patient's written acknowledgement of receipt of the Notice of Privacy Practices must be obtained on the date the first service is rendered to the patient. However, a medical practice is NOT required to obtain the patient's written acknowledgement of receipt of the Notice of Privacy Practices under the following circumstances:

In the event of an emergency, though the practice must use reasonable efforts to obtain such acknowledgement as soon as reasonably practicable after the emergency.

If a patient refuses to sign the acknowledgement and the practice documents such refusal.

Authorizations

A health care provider must obtain written permission, or "authorization," as it is referred to in the HIPAA Privacy Rule, to use or disclose the individual's PHI for purposes other than for

TPO. The authorization must contain certain specified information (depending to some extent on whether the authorization is initiated by the patient or a covered entity); but generally it must describe the provider who is the release the PHI; the records to be used or disclosed; to whom the information will be disclosed; the purpose of the request; and an expiration date for the authorization. There are situations when an authorization is not required, such as (1) when use or disclosure implicates certain public health interests; (2) when necessary to report abuse or neglect; (3) in certain stages of law enforcement and judicial proceedings; (4) in emergency situations; and (5) other exceptions specified in the regulations.

Accountings

A covered entity must keep an accounting of any disclosures that are not TPO and not authorized by the patient, which should be rare in most physician offices, but could include mandatory abuse reporting and other law enforcement and health oversight activities.

If the covered entity uses an Electronic Health Record, then the exception for accounting for TPO does not apply, although the individual only has the right to receive an accounting for the last three years. By August 2010, DHHS will promulgate regulations regarding the standards for disclosure of TPO. If your practice used an Electronic Health Record as of January 1, 2009, this requirement to provide an accounting of TPO applies to disclosures made on and after January 1, 2014. If your practice acquires an Electronic Health Record after January 1, 2009, the provision applies the later of January 1, 2011, or the date your practice acquired an Electronic Health Record. In other words, if you are considering an Electronic Health Record system, you should make certain that this capability for accounting of TPO disclosures is part of the system.

Business Associates

Many medical practices require assistance from outside entities to accomplish some or all of their business activities and functions, such as billing and collections, marketing, and technology services. Many of these types of entities may be identified under the Privacy Rule as "Business Associates."

A Business Associate is a person or entity that is not a member of your practice's workforce who uses or discloses PHI to carry out certain functions or activities on behalf of your practice. The Privacy Rule requires that your practice execute a Business Associate Contract with each business associate prior to the use or disclosure of PHI.

Under the HITECH Act, effective February 17, 2010, Business Associates are directly regulated and are subject to HIPAA's obligations regarding administrative, physical, and technical safeguards for electronic PHI. The new HITECH privacy and security requirements apply to Business Associates as they do to Covered Entities, as do the HIPAA penalty provisions. Also, under the HITECH Act, any entity that provides data transmission of protected health information is considered a business associate and must enter into a business associate agreement with the covered entity.

Privacy Officer

The practice must designate a Privacy Officer. Especially in smaller offices, this will often be the office manager or someone else with existing duties. The Privacy Officer will be responsible for the implementation of the Privacy Rule as well as for the development of the practice's policies and procedures regarding the rule.

Notice of Breach of Unsecured PHI

The HITECH Act provides a new requirement for covered entities when there is a breach of unsecured PHI. "Unsecured PHI" means PHI that is not made unreadable, unusable, or indecipherable through the use of encryption or destruction. A breach is any unauthorized use, disclosure, or acquisition of PHI that compromises the security or privacy of the PHI. Certain unauthorized disclosures are not considered breaches—for example, a disclosure that does not pose a significant risk of financial, reputational, or other harm to the individual, or the disclosure of information that is adequately de-identified as provided in the statute.

If a breach does occur, either by the covered entity or its business associate, the covered entity must notify the individuals whose unsecured PHI has been acquired or disclosed as a result of the breach. Notifications are to be made without delay and in no case later than 60 days after the discovery of the breach.

If the unsecured PHI of 500 or fewer individuals is involved, the notice should be by mail at the last known address of the individual. If no address is available, a substitute means of notification may be used, which may include posting on the covered entity's web site.

If the unsecured PHI of more than 500 individuals is involved, notice must be provided to prominent media outlets. Notification must also be made to the Secretary of The Department of Health and Human Services immediately. In either case, the notification should include:

- A brief description of what happened and when;
- A description of the types of unsecured PHI that were involved in the breach;
- The steps individuals should take to protect themselves from potential harm resulting from the breach;
- A brief description of what the covered entity is doing to investigate the breach and mitigate losses, and
- Contact procedures for individuals to ask question or learn additional information.

Complaints, Enforcement of Privacy Rule

The U.S. Department of Health and Human Services' Office of Civil Rights (OCR) is responsible for enforcement of the Privacy Rule. The OCR has several responsibilities:

- Investigating complaints it receives from individuals who believe that a covered entity such as a medical practice is not complying with HIPAA's privacy requirements;
- Providing covered entities, such as a medical practice, with assistance in order to achieve compliance, and
- Making determinations regarding exceptions to state law preemption.

Any person or organization can file a complaint with the OCR, but complaints generally must be filed within 180 days of the occurrence of an action in violation of the Privacy Rule. Your practice is required to maintain records related to its compliance with the Privacy Rule in order for OCR to determine whether the practice is in compliance with HIPAA's requirements. Additionally, your practice must cooperate with an OCR investigation or compliance review should these occur.

For Penalties, see below.

Security Rule

The Security Rule focuses on requirements for covered entities (including medical practices) to protect and safeguard the confidentiality of electronic protected health information. As previously noted, Business Associates are required to comply with these provision as of February 17, 2010. The Security Rule addresses the transmission, storage and receipt of electronic data.

The Security Rule has three broad categories: (1) Administrative Safeguards, which are formal, documented practices to protect electronic PHI, including the use of security measures and the management of personnel. For instance, each clinic must conduct a "risk analysis," implement security measures to reduce risks, and apply appropriate sanctions against workforce members who fail to comply with security procedures, have a data backup plan, and have written arrangements with business associates. (2) Physical Safeguards, which are procedures to protect computer systems, buildings, and other equipment from fire and other natural and environmental hazards, as well as from intrusion. Requirements under Physical Safeguards includes policies on how to handle final disposition of electronic PHI and how to remove protected data from electronic media before media is re-used. (3) Technical Safeguards, which are processes to control and monitor access to electronic PHI, such as passwords, as well as to limit unauthorized access to data that is transmitted over a network (internet, intranet, etc.). Requirements include unique user identifications and emergency access procedures. Encryption and "automatic log-offs" are "addressable" features, but not necessarily required.

The Security Rule contains "required" implementation specifications and a variety of "addressable" specifications. Specifications that are required must be implemented. Those that are addressable have to be implemented by the following process: First, decide if the addressable specification is "reasonable and appropriate" to implement in your practice. If so, your practice must implement it. Second, if it is unreasonable or inappropriate but the standard cannot be met without implementation of an additional security safeguard, the practice may implement an alternative measure that accomplishes the same end. You must document the rationale behind the decision and the alternative measure chosen. However, if your practice decides that an addressable specification is simply not applicable to your practice (that is, neither reasonable nor appropriate) and that the specification can be met without implementation of an alternative measure, you must document this decision, the rationale behind it, and how the standard is still being met.

CMS has emphasized that the Security Rule is "scalable," meaning that it is meant to be interpreted flexibly, allowing each covered entity and business associate to tailor the requirements to the specific needs and resources, especially in the case of small providers. Each covered entity is required to designate a Security Officer, who can be the same person as the Privacy Officer. Like the Privacy Rule, the Security Rule supersedes contrary state laws.

<u>Electronic Transactions and Code Sets Rule</u>

The third major "Administrative Simplification" rule governs electronic health care transactions and code sets to be used in these transactions. Under this rule, physicians and all other providers who submit claims electronically must use the Electronic Data Interchange standards for billing and other health care transactions. If providers do not want to submit claims in standard format, they can contract with a clearinghouse to convert their claims into standard format. All health plans, including Medicare and Medicaid, are required to use the HIPAA standards.

While this Rule does not require providers to submit claims electronically, Medicare no longer accepts paper claims except for very small practices. As for Arkansas Medicaid, Provider Electronic Solutions (PES) software used by Medicaid is free to all providers, and they need to use the latest version (or another compatible software product) to remain in compliance with the HIPAA transaction standards.

Penalties & Enforcement of Administrative Simplification Rules

Improper use or disclosure of PHI can result in the following fines and/or imprisonment, as set forth under HIPAA:

A person who knowingly violates HIPAA and obtains PHI about, or discloses PHI to, another person may be fined up to $50,000 and imprisoned up to one year, or both.

If the offense is committed under false pretenses, the fine may be up to $100,000 and imprisonment up to five years.

If the offense is committed with the intent to sell, transfer, or use PHI for commercial advantage, personal gain, or malicious harm, the fine may be up to $250,000 and imprisonment up to 10 years.

In addition to these penalties, the Secretary of DHHS may impose civil monetary penalties on a covered entity or a business associate who violates HIPAA. The HITECH Act significantly increased the civil monetary penalties that can be assessed by the Secretary. The amount of the penalty depends on whether the provider knew or should have known that the practice was a violation, whether the violation was due to reasonable cause or willful neglect, and whether the violation was corrected during 30 days. Penalties range from not more than $100 for a provider who did not know that the practice was a violation to in excess of $1.5 million for identical violations in the same calendar year.

State Laws

HIPAA does not preempt all state laws. However, it does preempt those state laws that provide less protection to the patient and those that are "contrary" to HIPAA. Most Arkansas laws affecting health information are not preempted or can be reconciled fairly easily. However, there are some important exceptions. ***Practitioners should seek advice from legal counsel before making any disclosures in reliance on a state law***.

HEARING INSTRUMENT DISPENSING

Dispensers must have a license from the Arkansas Board of Hearing Instrument Dispensers unless the dispenser is a licensed audiologist, or makes the recommendation as part of an accredited educational program or as part of a program conducted by certain charitable or non-profit institutions. The law requiring licensing does not prohibit licensed physicians who specialize in otology or otolaryngology from treating or fitting hearing instruments.
Ark. Code Ann. §§ 17-84-102; 302.

Prior to applying for a dispenser's license, applicants generally must complete a one-year employment internship under direct and physical supervision of a sponsor who has continuously held in good standing, for a period of not less than three years, either a valid Arkansas hearing

instrument dispenser's license or a valid Arkansas audiology license. Before the beginning of the internship period, the applicant must receive Board approval of the application and training schedule as well as pay the internship fee prescribed by the Board.

After successful completion of six months of the internship program, the applicant may take the licensing examination upon written recommendation of the sponsor. If the applicant satisfactorily passes the exam, he or she may complete the one-year term under the oversight of the sponsor without personal and physical supervision if he or she works out of the same place of business as the sponsor. However, if the applicant fails the examination, he or she must complete the full one-year internship before reexamination. Any examination taken during an internship will be considered as one of three attempts to pass the licensing examination.

Among other things, an applicant for a license or an internship must be twenty years or older, must possess an education equivalent of two years of accredited college-level course work, and must be of good moral character.

Prior to applying for a license, an applicant either must complete the one-year internship, hold a National Board of Certified Hearing Instrument Sciences Certification, be registered as a hearing instrument dispenser in good standing in another state with licensing requirements that meet or exceed Arkansas' at the time of application, be a graduate of an American Conference of Audioprosthology program, or hold an Associate of Applied Science degree in Hearing Health Care Practitioner or a similar degree from an accredited educational institution.

Ark. Code Ann. § 17-84-304, as amended by Act 428 of 2007.

HUMAN GROWTH HORMONE

Human growth hormone generally refers to somatrem, somatropin, or one of their analogues. The term includes those hormones taken from a cadaver and those hormones synthetically produced.

Distributing, possessing, or counterfeiting human growth hormones outside the order of a physician constitutes a Class D felony. However, a person commits a Class C felony when he distributes or intends to distribute human growth hormones to someone less than 18 years of age without a prescription.

The volume of human growth hormone possessed by a person may establish that the person intended to distribute the hormone to another person. Intent to distribute is established by the possession "of more than 200 capsules or tablets or more than 16cc. of human growth hormones or counterfeit substance."

Ark. Code Ann. §§ 20-56-202, 205.

IMMUNIZATIONS

Children

The Department of Health maintains a childhood immunization registry. Physicians may receive information from the registry when needed to provide care to a child.

Rules and Regulations Changes for 2010

The Arkansas State Board of Health has revised the rules and regulations pertaining to immunization requirements and intends to distribute these rules in early 2010. The changes add advanced practice nurses to the list of those who may provide immunization records and to allow the printout of an immunization record from the immunization registry to serve as an official immunization record needed for child and student files. The changes also accommodate changes in vaccines, allow for alternate schedules when initial doses are received late, modify when history of disease may be accepted in lieu of vaccine, and clarify enforcement authority. These changes include tables to summary the requirements for both students in kindergarten through 12th grade and in colleges and universities. For further information, call the Department of Health at (501) 661-2000 or visit http://www.healthyarkansas.com/rules_regs/rules_regs.htm.

Duty to Register

Physicians giving immunizations to persons under 22 years of age must register with the Department of Health. Further, the physician must file a report for each immunization performed. Failure to register or report results in a fine of $25.00 and/or removal from the Vaccine For Children program. The Health Department's regulations on immunization reporting set out the required information for each report.
Ark. Code Ann. §§ 20-15-1201 to 1203; Ark. State Board of Health Rules and Regulations Pertaining to Immunization Reporting.

Admittance to Schools

Infants or children attending a child care facility or school in Arkansas must receive age-appropriate immunization for poliomyelitis, diphtheria, tetanus, pertussis, red (rubeola) measles, rubella, Haemophilus influenzae type b, hepatitis B, pneumococcal disease, and varicella (chickenpox). A licensed physician or a public health department must certify that an immunization was administered.

Proof of Immunization

The only proof of immunizations to be accepted shall be an immunization record by a physician or advanced practice nurse, or from the health department, military service, or an official record from another educational institution in Arkansas. The certificate must state the vaccine type and dates of administration. Terms such as "up to date," "complete," "adequate," etc., are not to be accepted as proof of immunization. *Section III.D.1.*(b), *Ark. State Board of Health Rules and Regulations Pertaining to Immunization Requirements.*

Proof of Immunity

Persons who can prove by appropriate serological testing that they have immunity to a vaccine-preventable disease are not required to be vaccinated for that disease. A copy of the serological test should be submitted to the Health Department's Immunization Section, along

with a letter requesting that the serological test be accepted as proof of immunity. The Immunization Section will respond with a letter indicating approval or denial.

Additionally, proof of birth before January 1, 1957, will be accepted by educational institutions in lieu of serological testing and will exempt the person from the required immunizations for students.

Exemptions

Parents or legal guardians who object to vaccinations on medical, religious or philosophical grounds must complete an annual application process through the state Department of Health to obtain an exemption for their child. Only the Arkansas Department of Health may grant certificates of exemption. For a medical exemption, only a letter issued by the Medical Director, Immunization Section, will be accepted as a valid medical exemption. *Section IV. B.1*., *Ark. State Board of Health Rules and Regulations Pertaining to Immunization Requirements* (. Statements from private physicians alone are not sufficient as certificates of exemption.

Certificates for Child with Disability

A child who is deemed to have a physical disability contraindicating vaccination may be issued a certificate of exemption. This exemption from vaccination will no longer apply if the disability is removed.

The pertussis immunization requirement does not apply to a child whose sibling possesses a total permanent disability from an adverse reaction to the pertussis antigen. This exemption applies to siblings of whole or half blood.

Objection to Immunization

The immunization requirements do not apply when the parents of the child object to the vaccination on religious or philosophical grounds and the exemption application process has been successfully completed through the Department of Health.

Immunizations for Enrollment at Universities and Colleges

Students of universities must furnish proof of immunization for measles, rubella, and other communicable diseases, or proof or immunity, or proof of birth before 1957, or a medical or non-medical certificate of exemption. If a medical doctor licensed to practice in Arkansas concludes immunization is medically contraindicated, and he signs a certificate approved by the Department of Health, the certificate can be accepted by a college or university in lieu of proof of vaccination.

*Section IV.B.3, Ark. State Board of Health Rules and Regulations Pertaining to Immunization Requirements (*J*; Ark. Code Ann. § 6-18-702,; Ark. Code Ann. §§ 6-60-502, 504.*

Health Care Workers and Public Safety Personnel

Smallpox Vaccinations

In response to the federal Homeland Security Act of 2002, voluntary smallpox vaccinations for health care workers and public safety personnel became available on February 19, 2003. If a worker incurs an adverse reaction from the vaccination, the worker may be compensated under Workers' Compensation law.

Ark. Code Ann. § 11-9-102.

Mandatory Vaccination Program for "First Responders"

Arkansas law creates a vaccination program for first responders to bioterrorism attacks, contingent on receiving federal funding. "First responders" include "emergency medical personnel who will be deployed to bioterrorism attacks, terrorist attacks, catastrophic or natural disasters and emergencies."

Participation in the vaccination program is mandatory for those first responders who are classified as having occupational exposure to bloodborne pathogens as defined by the Occupational Health and Safety Administration Standard in 29 *Code of Federal Regulations* § 1910.1030, in effect on January 1, 2003, or as otherwise required by law. Under the federal regulations, "bloodborne pathogens" means pathogenic microorganisms present in human blood that can cause disease, including, but not limited to, hepatitis B virus (HBV) and human immunodeficiency virus (HIV). "Occupational exposure" means "reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from performance of an employee's duties. The regulations define "parenteral" as "piercing mucous membranes or the skin barrier through such events as needlesticks, human bites, cuts and abrasions."

Participation in the vaccination program is voluntary for those first responders who do not have occupational exposure to bloodborne pathogens. The state Department of Health is to offer the vaccination program and to notify first responders of its availability.

Ark. Code Ann. § 20-13-1202.

IMPAIRED PHYSICIANS

Treatment of Impaired Physicians

The Arkansas State Medical Board may order an evaluation of an "impaired physician." "Impaired" means "the presence of the diseases of alcoholism, drug abuse, or mental illness."

The Physicians' Health Committee of the Arkansas Medical Society shall conduct the evaluations. The committee shall report evaluation findings to the Arkansas State Medical Board, refer impaired physicians to treatment programs, and monitor and provide treatment, rehabilitation, and post-treatment support.

Treatment Program Participation

A hospital may not deny hospital staff privileges to any physician solely because of participation in a treatment program.

Physician-Requested Restriction

An impaired physician may voluntarily request and receive a restriction on his license to practice from the board. Removal of a requested restriction shall be pursuant to the procedures for reinstatement of licensure.

See Licensing, Physician, page 145.

Confidentiality

Committee records concerning an impaired physician are considered confidential. In addition, unlike some other types of "confidential" records, committee records cannot be reached

by discovery or subpoena. Records that are available from original sources, however, are not immune from discovery. For example, those records on file at a hospital are considered "original," and even though they are considered confidential, hospital records are available through discovery or subpoena.

Further, no person "shall be required to testify as to any committee discussions or proceedings." Persons may be required to testify on matters within their knowledge except for any testimony or opinions formed during a committee hearing.

Limited Liability as to the Committee

The Physician's Health Committee cannot be held liable for any acts, omissions, or recommendations that it makes in good faith. Further, no person acting "in good faith and without malice" can be held liable for reports made to the committee.
Ark. Code Ann. § 17-80-201 and following.

INSURANCE

Most recent managed care laws tend to apply to both insurance companies and HMOs, as well as other types of managed care entities.

Prompt Payment of Claims

Pursuant to the statutory authority to regulate insurance companies and HMOs, the Arkansas Insurance Department has promulgated regulations governing "unfair claims settlement practices." Under Rule and Regulation Number 43, insurance companies and HMOs have 30 days after receipt of an electronically submitted "clean claim" in which to pay or deny it; a 45-day time period applies for claims submitted by other means. A "clean claim" means a claim for payment of health care expenses submitted on a CMS 1500, a CMS 1450 or UB-04 (formerly the UB92), in a format required by the Health Insurance Portability and Accountability Act of 1992 ("HIPAA"), or on the carrier's standard claim form with all required fields completed in accordance with the insurer's or HMO's published claim filing requirements. A "clean claim" does not include a claim (1) for payment of expenses incurred while premiums were delinquent; (2) for Medicare supplemental policy benefits if the claim is not accompanied by an explanation of Medicare benefits or the Explanation of Medicare Benefits ("EOMB") has not been otherwise received by the insurer or HMO; (3) for which the insurer or HMO needs additional information in order to resolve certain issues, including whether an exclusion applies, obtaining missing medical information to determine the price for a medical procedure without a CPT Code or HCPC Code.

If the insurance company or HMO needs additional information and more time to process a claim that is not a "clean claim", it must notify the claimant within 30 days after it received the claim. If additional information is required, the notice must give an explanation of what is needed. Once it receives the additional information, it has 30 days to pay or deny the claim.

Insurers who fail to meet the time requirements for paying or denying a clean claim or for providing notice "shall pay" a penalty to the insured, the amount of which is determined by a formula set out in Rule and Regulation 43. The insured does not have to take any action to force the insurer to pay the penalty.

Rule and Regulation 43 sets out timeliness standards for processing of claims by category; for example, that 85% of clean claims be processed within 30 days. However, the percentages are not mandatory, and the insurer or HMO can obtain a waiver in certain circumstances. The Insurance Commissioner can require the insurer or HMO to provide him with a report showing the timeliness of processing various categories of claims. The Insurance Commissioner may impose a remedial action plan or take other action against an insurer or HMO who has fallen below these standards: 60% of claims processed within 30 days and 85% of claims processed within 45 days.

Insureds can file consumer complaints with the Commissioner over how quickly a claim is processed, in certain circumstances. The complaint must be investigated and a report provided to the person who filed the complaint.

There is a statutory provision regarding small claims, but it has proved to be unenforceable for the most part. A company or organization that issues a medical, hospital, or accident policy or plan and which denies liability or does not pay within a reasonable time after demand, will be liable to the insured for twice the amount of the benefit if the benefit is less than $300. However, the law does not define the length of "reasonable time," and governmental and nonprofit organizations are exempt.

Ark. Code Ann. § 23-79-135; Arkansas Insurance Department Rules, Regulation 43 (Effective January 1, 2001) found at http://www.insurance.arkansas.gov/Legal%20Dataservices/rnrpage.htm

Penalty for Late Payment of Claims

Health carriers must pay a twelve percent per year penalty for late payment of claims due under health insurance contracts. The claimant need not demand payment for the penalty to apply. A health carrier's hiring a third-party administrator or other person to process claims will not relieve the health carrier of its obligation to pay the penalty.

"Health carrier" refers to health maintenance organizations, hospital and medical service corporations, and health insurance companies. The penalty does not apply to self-funded plans except to self-insured governmental or church plans and third-party administrators who administer or adjust benefits for any of those carriers.

Ark. Code Ann. § 23-66-215.

Insurance Recoupment from Physicians

Arkansas statutes limit a health insurer's ability to recover money it paid to a physician or other health care provider. The term for this kind of recovery is "recoupment", which is defined in the law as any action by a health care insurer to recover or collect payments already made to a provider by reducing other payments currently owed, by withholding or setting off the recoupment amount against current or future payments, by demanding payment back from the provider, or by taking other actions that reduce or effect future claims payments to the health care provider. Except in cases of fraud committed by the health care provider, a health care insurer may only exercise recoupment during the 18-month period after the claim was paid.

Any health care insurer seeking recoupment must give the provider a written or electronic statement specifying the basis for the recoupment, stating the amount of the recoupment, the patient's name and identification number, date of service, service on which the recoupment is based, pending claims being recouped or future claims that will be recouped, and specific reason for the recoupment.

If an insurer determines that payment was made for services not covered, the insurer must

give written notice to the health care provider of its intent to recoup, and the insurer may request a refund or make recoupment. If the health care provider or other party on its behalf verified with the insurer that an individual was covered, if the provider in good faith provided services in reliance on that verification, and if the provider did not act fraudulently, then there are restrictions on the insurer's ability to recoup on the basis that the services were not covered. The insurer has 120 days from the date of payment to notify the provider of a verification error and the fact that services rendered will not be covered if the error was made in good faith at the time of the verification.

Failure to comply with the provisions of this law will be deemed an unfair trade practice under the Trade Practices Act, Ark. Code Ann. § 23-66-201 and following.
Ark. Code Ann. § 23-63-1801 and following.

Reimbursement for Physician Assistant Service

A health plan cannot refuse to reimburse a physician at the full rate for health care services provided by a physician's assistant if the practice complies with state law. A health plan also cannot impose a practice or supervision restriction on a physician assistant that is inconsistent with or more restrictive than the restrictions already imposed by the state.
Ark. Code Ann. §23-79-154, as amended by Act 458 of 2007.

Subscriber Identification Cards

Effective with contracts issued, renewed, or amended after July 31, 2007, no contracting agent (preferred provider organization, third party administrator, prescription benefit management company, health maintenance organization, hospital and medical service corporation, self-insured health plan) can sell, lease, assign, convey, or otherwise grant access to the contracting agent's panel of contracted health care providers or the contracting agent's contracted reimbursement rates to another entity unless authorized in an agreement between the contracting agent and the provider. At least annually and upon written request of a contracted provider, a contracting agent must disclose in writing or electronically to its providers all payors and other entities to which the contracting agent has sold, leased, assigned, or otherwise granted access to the contracting agent's panel of contracted health care providers and reimbursement rates.

A subscriber identification card must state, in a clear and legible manner, the network applicable to provider claims arising from the use of that card. Any contractual discounts or alternative rate of payments are enforceable only to the network identified on the card.

This requirement does not apply to an insurance company, health maintenance organization, or any other entity when the entity provides health benefits directly through its own network to its own enrollees.

The Insurance Commissioner will adopt rules for the implementation, administration, and enforcement of this section as well as enforce this section.

The provisions of this act do not apply to the Arkansas Comprehensive Health Insurance Pool.
Act 686 of 2007, codified at Ark. Code Ann. §23-63-113.

Any Willing Provider Law (Patient Protection Act)

The Patient Protection Act of 1995, commonly known as the "Any Willing Provider" Law ("AWP"), finally went into effect in 2005. The law requires all HMOs and other entities defined

as "health care insurers" to accept into their provider networks all providers covered by the Act who are willing and able to meet the insurer's terms and conditions. The Act now covers 28 different types of providers, including physicians, dentists, ambulatory surgical centers, and hospitals. Effective January 1, 2007, the Arkansas Insurance Department included non-hospital based medical facilities providing clinical diagnostic services for sleep disorders and non-hospital based medical facilities providing magnetic resonance imaging, computed axial tomography, or other imaging diagnostic testing. *Arkansas Insurance Department Rule, Regulation 86 (effective January 1, 2007).*

The 1995 AWP law has been amended by two other acts passed in 2005: Act 491, which more clearly defines which types of health benefit plans are subject to AWP, and Act 960, which allows providers to sue for injunctive relief under the AWP Law, but not damages.

What follows is a condensed version of the Arkansas Insurance Department's Directive 2-2005 issued July 15, 2005, which interprets the Arkansas AWP Law in light of the 2005 Eighth Circuit opinion that finally led to AWP's implementation.

The Department applies AWP to all fully-insured health benefit plans insured by group and individual accident and health policies, health maintenance organization contracts, hospital and medical service contracts, and any other "health benefit plan" defined in Act 491 of 2005. Generally, health benefit plans that are not subject to AWP include *self-funded* employer plans, even if the health plan hires an insurance company to administer plan benefits or pays for access to a health insurer's provider network.

The Insurance Department bulletin describes types of group health benefit plans most common in Arkansas to further clarify the application of AWP to health benefit plans:

Health Benefit Plans Subject to the AWP Law

1. Insured ERISA plans. These health benefit plans are fully subject to the 1995 AWP, as amended, and provider networks used by them must be AWP-compliant. This is true even if a "non-insurer" provides the plan with a network of medical providers. In other words, with regard to insured plans, the ultimate responsibility for compliance with AWP rests with the health insurer.
2. Self-funded ERISA plans. As a result of the litigation that finally mandated implementation of the 1995 AWP law, self-funded ERISA plans are AWP-exempt, and the 1995 AWP, as amended, cannot be used to directly or indirectly regulate the operations of self-funded ERISA plans.
3. Self-funded *non*-ERISA health benefit programs. Some group health benefit plans are not subject to the ERISA statutory regime, including but not limited to, governmental health benefit plans and church plans. However, these *non*-ERISA plans are covered by the 1995 AWP unless (1) they are self-funded and (2) contract directly with a "non-insurer" (such as a typical Physician Hospital Organization, Independent Practice Association, or third-party administrator) to provide the plan with a network of medical providers. Please note however that if a non-ERISA plan, whether self-funded or insured, arranges with a health insurer to provide the plan with a network of medical providers, the plan is subject to the 1995 AWP as amended. Again, this paragraph applies in the unique circumstances of *non*-ERISA plans. Most group plans, whether self-funded or insured, are ERISA plans.

4. Arkansas State Employees Health Benefit Plan. Legislation passed in 2009 provides that any health benefit plan provided by the state to its employees and public school personnel is subject to AWP. *Act 702 of 2009, codified at Ark. Code Ann. § 23-99-1801(e).*
5. Workers' Compensation Health Benefits. The Department's position is that AWP was not intended to apply to workers' compensation health benefits.

Health Care Providers Entitled to Any Willing Provider Rights

Medical providers entitled to request AWP access are listed in Act 491 of 2005 and include physicians. The Insurance Department has the authority under the AWP law to add classes of providers to the list of classes subject to the law. At this time, the Department has added only the two provider classes listed above (sleep disorder clinical diagnostic services and diagnostic imaging at non-hospital based medical facilities). There is no requirement in the AWP law to provide coverage of any particular health care service. If the service of a particular class of providers (e.g., chiropractors, dieticians, hospice, etc.) is included in the health benefit plan, then all providers in that same class who qualify for membership are eligible to be part of the plan's network.
Ark. Code Ann. §§ 23-99-204(b) and 205;; Ark. Code Ann. § 23-99-801(c).

Health Care Provider Requests For Network Access

AWP does not describe the mechanics and timing of health care provider requests for network access with the health care insurer. Providers interested in being admitted into a network should contact the insurer or HMO for an application. The Department advises every HMO and accident and health insurer to promptly give providers a written application and a description in writing of the application process for each medical provider requesting network access with the health care insurer. In addition, the health care insurer should provide a written description of the health care insurer's terms and conditions, schedule of fees, covered expenses, and utilization regulations and quality standards. The AWP statute requires that the health care insurer "apply such terms and conditions in a nondiscriminatory manner." As the result of 2009 legislation, health care insurers are now generally required to make a decision within 90 days on a physician's request for participation in the plan. *Ark. Code Ann. § 23-99-411(a); Ark. Code Ann. § 23-99-801(a).*

*See **Arkansas Health Care Consumer Act**, Processing Provider Applications at Page* 136.

Restriction on Health Care Provider Discrimination

Arkansas law prohibits health care insurers from imposing any monetary advantage, penalty, or higher copayment under a health benefit plan that would affect a beneficiary's choice of health care providers. AWP prohibits the imposition upon a beneficiary of a health care service any copayment, fee or condition that is not equally imposed on all beneficiaries in the same benefit category, class, or copayment level when the beneficiary is receiving services from a participating health care provider. However, the law does not prohibit varying the level of co-payment, fee or condition as between provider types.
Ark. Code Ann. § 23-99-201 to 209;. Ark. Code Ann. §§ 23-99-801 to-803; *Arkansas Insurance Department Directive 2-2005, July 15, 2005.*

See also, Health Maintenance Organizations, Point-of-Service Requirement, at page 141.

Arkansas External Review Regulation

An Arkansas Insurance Department regulation, titled "External Review Regulation", permits individuals covered by health benefit plans to obtain an independent review, in certain circumstances, of a plan's determination that a requested payment should be denied, reduced or terminated for health care services. The regulation applies to most kinds of health insurance plans. The plan must notify the covered person and his treating health care professional in writing or via electronic media of the covered person's right to request an external review of adverse determinations. The regulation sets out detailed procedures and timelines for the external review process.

Arkansas Insurance Department Rules,Regulation 76, effective September 20, 2002.

Coverage for Certain Cancer Drugs

Any insurance policy that covers prescription drugs must not limit or exclude coverage for any cancer-treating drug approved by the U. S. Food and Drug Administration (FDA) on the basis that the drug has not been FDA-approved for treatment of
the specific type of cancer for which it is being prescribed, as long as certain other requirements are met. Coverage must be provided if the drug has been recognized as "safe and effective" for the treatment of the specific type of cancer in the American Hospital Formulary Service Drug Information, the National Comprehensive Cancer Network Drugs and Biologics Compendium, or the Elsevier Gold Standard's Clinical Pharmacology, and the use has not been identified as "not indicated" in any of those publications.

Coverage of the drug also must be provided if the drug has been recognized as "safe and effective" for treatment of the specific type of cancer in at least two articles from "medical literature" that have not been contradicted by "clear and convincing" evidence from other medical literature. "Medical literature" means articles from major peer-reviewed medical journals specified by the U.S. Department of Health and Human Services, pursuant to federal law. Other authoritative compendia as identified by the Secretary of the federal Department of Health and Human Services or the Arkansas Insurance Commissioner may be used to provide coverage by an insurer at the insurer's discretion.

Insurance coverage required by this law also includes medically necessary services associated with the administration of the drug, provided such services are covered by the insurance policy.

Ark. Code Ann. § 23-79-147, as amended by Act 270 of 2009.

Coverage for Colorectal Cancer Examinations

A health care policy, other than certain limited benefit plans, that is executed, delivered, issued for delivery, continued or renewed in Arkansas after August 1, 2005, must cover colorectal cancer examinations and laboratory tests. The coverage shall include colorectal cancer examinations and laboratory tests for covered persons who are 50 years of age or older, who are less than 50 years of age and at high risk for colorectal cancer according to the American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005, and persons experiencing certain symptoms set out in the statute. The statute also details what the screening process should include.

Ark. Code Ann. § 23-79-1201 and following.

Coverage for Contraception

All health insurance policies, other than certain limited benefit plans, that provide coverage for outpatient prescription drugs, must provide coverage for prescribed drugs or devices approved by the U.S. Food and Drug Administration for use as a contraceptive. For any person receiving prescription contraception benefits, an insurer may not (1) impose a fee or co-pay that is not equally imposed on all persons in the same category, class or level who are receiving prescription drug benefits, or (2) reduce the allowable reimbursement for prescription drugs.

Nothing in this law may be construed as: (1) requiring an insurance company to provide coverage for abortion, abortifacients or any FDA-approved emergency contraception, (2) requiring coverage for contraception prescription benefits in any plan that does not otherwise provide prescription drug coverage, (3) precluding the use of closed formularies. (However, the formularies must include oral, implant and injectable contraceptive drugs, intrauterine devices and prescription barrier methods.) or (4) requiring any religious employer to comply with this law. "Religious employer" means an entity that is organized and operated for religious purposes and has an Internal Revenue Service 501(c)(3) designation, has as one of its primary purposes the inculcation of religious values, and which employs primarily persons who share its religious tenets.

Ark. Code Ann. § 23-79-1101 and following.

Coverage for Treatment of Bones and Joints of the Face, Head, and Neck

All health carriers must provide optional coverage for medical treatment of musculoskeletal disorders affecting the bones and joints of the face, head, and neck. Such treatment includes surgical and nonsurgical procedures. Carriers must provide treatment for those disorders as medically necessary without regard to whether the disorder is the result of trauma, accident, pathology, developmental defect, or congenital defect. The coverage must be the same as that provided for such disorder in other areas of the body and must be covered whether prescribed by a dentist or physician.

The policyholder must either accept or reject the option in writing on the application for coverage, and the application must specifically and conspicuously inform the policyholder that if he rejects the option, the coverage will not include temporomandibular joint disorder or craniomandibular disorder.

Ark. Code Ann. § 23-79-150.

Coverage of Medically Necessary Foods

All health insurance plans, other than certain limited benefit plans, must cover medically necessary foods, such as amino acid modified preparations, low protein modified food products and any other special dietary products and formulas prescribed under the direction of a physician for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism.

Ark. Code Ann. § 23-79-702, 703.

Coverage of Newborn Infants

All health insurance plans, other than certain limited benefit plans, that covers the insured and members of the insured's family shall include coverage for the insured's newborn infants from the moment of birth. The coverage must be the same as for other members of the insured's family and include coverage for illness, injury, congenital defects, premature birth, and for

testing for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, and any other screening or testing performed by or for the State of Arkansas or hereafter mandated by law. *Ark. Code Ann. § 23-79-129.*

Arkansas Health Care Consumer Act

The following provisions of the Arkansas Health Care Consumer Act of 1997 protect patients in the managed care environment. "Health insurers" include insurance companies and HMOs.

Benefits for Mothers and Newborns

A mother and her newborn child are entitled to a hospital stay of 48 hours following a normal vaginal delivery, or 96 hours following a Cesarean section. A health insurer may not restrict benefits for this period nor may it require the hospital or physician to authorize this length of stay. This minimum stay period may be reduced by the attending physician in consultation with the mother. *Ark. Code Ann. § 23-99-404.*

Mastectomies

The Arkansas Health Care Consumer Act requires health care plans that provide mastectomy benefits and that were issued or renewed after July 16, 2003, to conform to the requirements of a federal law titled the Women's Health and Cancer Rights Act of 1998, as that law existed on January 1, 2003. Each health insurer providing mastectomy benefits must, in a manner determined in consultation with the attending physician and the insured, not restrict the hospital stay of a person undergoing a mastectomy to less than 48 hours. Furthermore, health insurers that cover mastectomies must provide the following benefits if a patient elects breast reconstruction: (1) surgery and reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to provide a symmetrical appearance; and (3) prostheses for physical complications at all stages of a mastectomy, including lymphedemas. Health insurers must also provide written notice of the availability of coverage to the insured upon enrollment and annually thereafter.

No health insurer providing mastectomy benefits shall: (1) deny an insured eligibility or continued eligibility to enroll or renew coverage under the terms of the health plan solely for the purpose of avoiding the requirements on mastectomies, or (2) penalize, reduce, or limit the reimbursement of an attending provider or induce the provider to provide care in a manner inconsistent with this law.
Ark. Code Ann. § 23-99-405.

Obstetrical and Gynecological Services

Health insurers that require the selection of a primary care physician must allow women to select a participating obstetrician/gynecologist in addition to their primary care physician. A woman need not obtain a referral from her primary care physician to see her obstetrician/gynecologist. *Ark. Code Ann. § 23-99-406*

Gag Clauses

A health insurer may not prohibit a physician from disclosing to the patient any information that the physician finds appropriate regarding the nature, risks or alternatives to treatment; the process that is used by insurers to authorize or deny health care services or benefits; or information on financial incentives for providers used by the insurer. *Ark.Code Ann.§ 23-99-407.*

Continuity of Care

Health insurers that use participating providers must develop procedures to ensure the continuity of care of their beneficiaries when the employer changes health care plans. For example, a patient who is being treated for a current episode of an acute condition by a nonparticipating provider must be allowed to continue treatment under that provider as an "in-network benefit" until the current episode of treatment ends or until the end of 90 days, whichever occurs first.

When a provider's participation in the plan is terminated, his patients under the plan must be allowed to continue to receive care from that provider as an in-network benefit until the current episode of treatment for an acute condition is completed or until the end of 90 days, whichever occurs first.

During the specified time periods, these providers must be considered to be participating providers for the purposes of reimbursement, utilization management, and quality of care. *Ark. Code Ann. § 23-99-408.*

Prescription Drug Formulary

Health insurers that use a formulary for prescription drugs must provide a written procedure where beneficiaries can promptly obtain, without penalty, specific drugs and medications not included in the formulary when the formulary's equivalent has been ineffective in the treatment of the patient's disease or condition or the formulary's drug causes or is reasonably expected to cause adverse or harmful reactions. *Ark. Code Ann. § 23-99-409.*

Grievance Procedures

A managed care insurer must establish a grievance procedure that allows its beneficiaries to have prompt and meaningful review of denial of a treatment or service. The insurer must give the beneficiary a prompt written notice of the outcome of the grievance proceeding that includes specific findings when the outcome is adverse to the beneficiary. *Ark. Code Ann. § 23-99-410.*

Processing Provider Applications

Health insurers are required to timely process provider requests for participation or renewal. If a provider's request for participation or renewal has been denied, the insurer must give the provider a written statement of the reasons. Insurers have up to 90 days from the date of the submission of the completed application by a licensed physician and 180 days from the date of submission of the completed application by any other provider to reach a decision on the provider's status.

When a physician's credentials are verified through the Arkansas State Medical Board's Centralized Credentials Verification Service, the 90-day period is suspended temporarily from the date the order is received by the Centralized Credentials Verification Service from the health care insurer until the date the health care insurer receives notification by the CCVS.

If the information provided by the initial application, the health care insurer's investigation, or CCVS requires more detailed information, the time specified and the application are suspended temporarily from the date a written request for information is sent to the provider until the request is fully and completely answered and sent to the health care insurer. If the request is not fully answered in 90 days of the date sent to the provider, the health care insurer may treat the application as abandoned and deny it.

If a physician is already credentialed by the health insurer but changes employment or location, the health insurer must only require the submission of additional information as necessary to continue the physician's credentials based upon the changed information.

Health care insurers must promptly notify providers of any delay in processing applications and the reasons for a delay. *Ark. Code Ann. § 23-99-411.*

Provider Input

Health insurers issuing managed care plans are required to establish a mechanism for participating providers to give input into the insurer's medical policy, utilization review criteria and procedures, quality and credentialing criteria, and medical management procedures.

Orthotic & Prosthetic Devices and Services

Act 950 of 2009 added a provision requiring health insurers to provide coverage for an orthotic device, an orthotic service, a prosthetic device, and a prosthetic service within the limits of coverage that are no less than 80% of Medicare allowables. This new section does not require coverage for an orthotic or a prosthetic device or service for replacement that occurs more frequently than once every three years unless it is medically necessary or indicated by other coverage criteria.

Eligible charges and limits of coverage must be based on medical necessity or the insurer's coverage criteria for other medical services, which can include the information and recommendation from the treating physician in consultation with the insured as well as the results of a functional limit test. A functional limit test can include but is not limited to medical history, current condition, a desire to ambulate, or a desire to maximize upper-limb function. A denial or limitation of coverage based on lack of medical necessity is subject to external review by the Arkansas State Insurance Department.

Health insurers may require prior authorization for orthotic and prosthetic devices or services in the same manner that prior authorization is required for any other covered benefit. Health insurers may also impose co-payments, deductibles, or coinsurance amounts if the amounts are no greater than those amounts that apply to other benefits. When replacement or repair of an orthotic or prosthetic device is necessitated by anatomical change or normal use, the replacement or repair must be covered subject to co-payments, coinsurance, and deductibles that are no more restrictive than those applied to other covered benefits, unless the repair or replacement is caused by misuse or loss.

Health insurers must require that an orthotic and prosthetic devices or services be prescribed by a license doctor of medicine, osteopathy, or podiatric medicine and provided by a doctor, orthotist, or prosthetist licensed by the State of Arkansas.

Ark. Code Ann. §§ 23-99-417, as amended by Acts 350 and 950 of 2009.

Arkansas Health Insurance Consumer Choice Act

Insurers and HMOs may offer group or individual health insurance plans that do not provide all state-mandated health benefits. Before an insured's choice to enroll in such a plan will be given effect, however, the insured must sign a written acknowledgement to the effect that the insured understands that the benefits offered under the plan may not equal state-mandated health benefits. If the insurer fails to obtain the insured's signature on such an acknowledgment, the insured's plan will be deemed to provide all state-mandated benefits.

Ark. Code Ann. § 23-79-801 and following.

Hospice Care Coverage

"Hospice" or "hospice care program" means an autonomous, centrally administered, medically directed, coordinated program providing a continuum of home, outpatient and home-like inpatient care for the terminally ill patient. It uses an interdisciplinary team to assist in providing palliative and supportive care. Hospices are licensed by the state, and they are required to make care available 24 hours a day, seven days a week, on the basis of need, regardless of ability to pay. The State Hospice Office of the state Department of Health implements rules and regulations for hospice care. Those regulations are available at this Internet address: http://www.healthyarkansas.com/rules_regs/table_of_contents.htm.
Ark. Code Ann. § 20-7-117, as amended by Act 827 of 2007.

All Arkansas health and accident insurance providers must offer coverage for hospice facilities and hospice programs. The offer must be made to each master group contract holder. Any rejection of the offer by the contract holder or policy holder must be in writing. The insurance coverage must provide terminally ill patients with coverage for prognosis and treatment at least at the same rates of reimbursement as are provided for hospice care under Medicare in effect January 1, 1999. This requirement to offer hospice care coverage does not apply to contracts or policies providing "disability income insurance, specified disease insurance, hospital indemnity insurance, long-term care insurance, short-term limited duration insurance, accident only insurance, Medicare supplement insurance," or other supplemental insurance.
Ark. Code Ann. § 23-86-120.

Federal and State Mental Health Parity Laws

The Federal Mental Health Parity and Addiction Act, which took effect January 1, 2010, requires certain health insurance plans that include mental health coverage to provide mental health benefits at the same level as medical and surgical benefits, including deductibles, co-pays, and out-of-pocket expenses. The law ends limits on mental health coverage, such as 35 visits per year to a mental health professional and 30-day hospital stays, if the plan does not have similar limits for physical ailments. If the plan offers coverage for out-of-network physical illnesses, it must offer similar out-of-network coverage for mental health care. The law does not apply to employers with 50 or fewer employees. It also does not apply to a particular plan if the additional costs to the plan of providing the expanded coverage exceeds certain levels set in the statute.
Public Law No. 110-343.

Arkansas has its own law on this subject, the Arkansas Mental Health Parity Act of 1997, which was amended in 2009 to be more consistent with the federal law. However, there are still some differences. The Arkansas law requires insurers to offer individuals and small employer groups an option to purchase mental health coverage and substance abuse coverage that meets the requirements of the Arkansas law. The requirements of the 2009 Arkansas law apply to health benefit plans on the plans' start or anniversary dates, but in no event later than one year after October 3, 2009.

However, health care insurers may elect to exempt a plan from the Arkansas law if the insurer can demonstrate that actual compliance would cause an increase in the health benefit plan year of the actual costs of coverage by an amount that exceeds: (1) two percent for the first health plan year applied or (2) one percent for each subsequent health benefit plan year. Determination of increases to the actual costs of coverage must be made, certified, written, and prepared by a qualified and licensed actuary who is a member in good standing of the American

Academy of Actuaries, after the health care insurer has complied with the first six months of the plan year. If an insurer elects for the exemption, the insurer must notify the Insurance Commissioner, the policyholder, and the certificate holders/subscribers/enrollees covered by the plan. . The ARKids First program is required to provide parity for mental health care for persons with mental illnesses and the mental health treatment of person with developmental disabilities. Parity requires that there be no disparity between mental health care and other medical care in regard to the duration or frequency of coverage, the dollar amount of coverage, or the financial requirement.

Ark. Code Ann. §§ 23-99-501 to 512 as amended by Act 1193 of 2009; Ark. Code Ann. § 20-77-1104(4), as amended by Act 435 of 2009.

Diabetes Management

Health insurers must cover one life-time diabetes self-management training program for persons diagnosed with diabetes. The patient's physician must prescribe the training after determining that it is medically necessary. The insurer must offer further diabetes self-management training when the physician determines that it is medically necessary because of a significant change in the insured's symptoms or conditions.

An appropriately licensed health care professional must conduct the training. The health professional must have completed an educational program that complies with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

The insurer must also provide coverage for medically necessary equipment, supplies, and services for treatment of Type I, Type II, and gestational diabetes.

Ark. Code Ann. §§ 23-79-601 to 607.

Utilization Review

Utilization review may be either external or internal. External utilization review refers to a system of case-by-case evaluation of patient data conducted by insurers or other third-party payors or their agents to determine the necessity and appropriateness of medical care either before or after the delivery of services to a patient. It is a cost-containment strategy, and, theoretically, a measurement of quality. Most utilization review programs today emphasize prior or concurrent review, as opposed to post-service review. Thus, physicians intending to perform certain procedures are often required to get "prior-authorization" from the insurers if they wish to be paid. Likewise, hospitals are required to get "prior-authorization" from insurers for hospital admissions, anticipated lengths of stay, and continued lengths of stay.

Internal utilization review is basically the same except that it is conducted by a hospital or other provider organization's internal personnel with respect to its own services. As provider networks become more mature, more of them will be able to assume utilization review functions, shifting these activities away from insurers.

Under Arkansas law, a "private review agent" is responsible for the approval or denial of payment for hospital or medical services. An external utilization review agent may not conduct utilization review in Arkansas unless the Arkansas State Board of Health has granted the agent a certificate. Generally, however, in-house review agents do not have to have a certificate. Under Arkansas law, physicians and others who participate in hospital utilization review committees are immune from liability regarding decisions made as to utilization so long as they act in good

faith. However, one of the state laws authorizing the information exchange, Ark. Code Ann. § 20-9-304, may be pre-empted by the federal Health Insurance Portability and Accountability Act (HIPAA). Practitioners should consult legal counsel before relying on the state law.
Ark. Code Ann. §§ 20-9-902 to 903; § 20-9-304.

See HIPAA at page 115; Medical Records, Use of Records in Medical Research at page 179.

Preferred Provider Organizations (PPOs)

In Arkansas, Preferred Provider Organizations are offered through insurance companies and thus are subject to all the laws that apply to traditional indemnity carriers. They also are subject to the state's Any Willing Provider Law. ***See Any Willing Provider Law, page 130.***

Another provision bearing on the operation of PPOs in particular is the "freedom of choice" statute at Ark. Code Ann. § 23-79-114. This law requires insurance companies to allow patients the freedom to choose any of various licensed medical practitioners, including physicians, optometrists, podiatrists, psychologists, dentists, and certified registered nurse anesthetists. The Insurance Department takes the position that this means only that PPO panels must be open to "representatives" of all medical professions, not to any licensed practitioner who applies. In other words, in the Department's view, this statute does not have the same purpose as the AWP Law. Instead, it means that if the PPO offers a particular service or "benefit," it cannot limit a beneficiary to using an M.D. if other practitioners listed in the statute are licensed to perform the same service.
Arkansas Insurance Department Bulletin No. 9-85 (May 10, 1985) and No. 9-85A (July 18, 1985).

Health Maintenance Organizations

In 1975, the Arkansas General Assembly determined "that health maintenance organizations, when properly regulated, encourage methods of treatment and controls over the quality of care which effectively contain costs and provide for the provision, availability, and accessibility of services." For this reason, the General Assembly found it necessary to establish separate regulations from the insurance laws of Arkansas.

An HMO is a "health care plan," which means any arrangement whereby the HMO provides, arranges for, or reimburses the cost of health care services through an individually underwritten or group master contract, and at least part of the health care services are provided on a pre-paid basis as opposed to mere indemnification.

HMOs are regulated by both the State Insurance Department and the State Health Department. The Insurance Department oversees financial and operational aspects of HMOs, while the Health Department is charged with overseeing access and quality of care concernsAn HMO must have sufficient numbers of physicians and other health professionals to adequately cover the health care needs of its enrollees.
Ark. Code Ann. § 23-76-101 to 132, ; Ark. Code Ann. § 23-76-103 to 104, as amended by Act 429 of 2007, 107, 111 to 114, 116, and 122; Ark. Dept. of Health Rules and Regulations for HMOs (Rev. August 1998).

Certificate of Authority

HMOs are granted a certificate of authority to operate after providing assurances that they can provide appropriate access to services with an ongoing quality assurance program. They are required to report certain statistics, including those related to cost of operations, utilization, and

access to services. HMOs must establish an enrollee complaint system and report the number and causes of complaints to the Health Department and the Insurance Department.
Ark. Code Ann. §§ 23-76-108; 116.

Enrollees' Rights

An HMO enrollee may not be excluded from the plan or non-renewed except for the failure to pay the charge for coverage, or as otherwise permitted by the Insurance Commissioner. A section on prohibited practices is aimed primarily at false or misleading advertisements or information provided to enrollees.

Enrollees are entitled to specific types of information, including the health care benefits offered, any limitations on those benefits, total amount of cost to the enrollee, and a description of the complaint system. Enrollees are further entitled to thirty days' notice of any material change in the operation of the organization or the provider network which directly affects the enrollees.

Further, an enrollee must be notified in writing by the HMO of a termination of the primary care provider who provided health care services to the enrollee, and the HMO must assist the enrollee in transferring to another participating primary care provider. HMOs must also now provide a toll-free phone number where enrollees can contact the HMO.
Ark. Code Ann. § 23-76-101 to 131; Ark. Code Ann. § 23-76-103-104, as amended by Act 429 of 2007, 107, 111 to 114, 116, and 122; Ark. Dept. of Health Rules and Regulations for HMOs (Rev. August 1998).

Option for College Students

HMOs must allow college students who reside on campus the option of either (a) choosing two physicians -- one near home and one near the college residence --or (b) choosing one near home and changing to one near the college residence during school terms.
Ark. Code Ann. § 23-76-132.

Point of Service Requirement

An HMO may offer a "limited provider network" (i.e., restricted to participating providers) if it also offers a point-of-service (POS) option that allows enrollees to obtain covered services from non-participating providers. The value of the benefits under the limited provider network must be at least 80% of the value of the benefits provided under the POS plan. The HMO must set the premium such that projected incurred claims are not less than 80 percent of the premium. While the Arkansas "Any Willing Provider law" allows all willing and qualified providers to become participating providers, the POS law is designed to allow access, albeit at a surcharge, to those providers who are unable or unwilling to become participating providers. Also, the POS law applies only to HMOs and not to preferred provider organizations (PPOs) or other types of insurers.
Ark. Code Ann. § 23-86-401 to 406.

See Any Willing Provider Law, page 130.

Grievance System

HMOs are required to operate a grievance system that has been approved by the Insurance Commissioner after consultation with the Director of the Department of Health, to resolve

written complaints by its enrollees concerning health care services. The system must allow for appeals up to the Commissioner or Director. The HMO must report annually to the Commissioner and Director a description of the procedures used in the complaint system; the total number of complaints handled through the system, as well as their causes; and the number, amount, and disposition of malpractice claims settled during the year by the HMO. Finally, the HMO must maintain a file of complaints it received on matters other than health care services.
Ark. Code Ann. § 23-76-116; Ark. Dept. of Health Rules and Regulations for HMOs, Sec. XVI (Rev. August 1998).

Quality Assurance

HMOs must have quality assurance systems in place that include: a method for analyzing health care outcomes; peer review; collection of health care data; and appropriate recommendations for remedial action. The system must include studies on utilization and quality and analyze availability, accessibility, and continuity of care.
Ark. Code Ann. § 23-76-108; Ark. Dept. of Health Rules and Regulations for HMOs, Sec. XVIII (Rev. August 1998).

Authority of Insurance Commissioner and the Director of the Department of Health

HMOs are accountable to both the Insurance Commissioner and the Director of the Department of Health. For example, certificates of authority are issued by the Insurance Commissioner after the Commissioner and the Director have determined that the applicant has met the application requirements. Other areas of dual responsibility include review of annual reports, examinations, , and suspensions or revocations of certificates of authority.
Ark. Code Ann. § 23-76-108, 113, 122, 123; Ark. Dept. of Health Rules and Regulations for HMOs, (Rev. August 1998).

Periodic Examinations

Both the Insurance Commissioner and the Director of the Department of Health must examine HMOs at least once every three years, and they both may conduct more frequent examinations as they deem necessary to protect the interests of the state's citizens. HMOs must submit their books and records, including the medical records of individuals and physicians' and hospitals' records, and facilitate the examinations.

Both the Commissioner and the Director may, in lieu of conducting the examination, accept the report of an examination made by another state's Commissioner or Director.

If an HMO plans to cease providing services in this state, the HMO may apply to the Commissioner for a waiver of the examination. The Commissioner may waive an examination, or reduce its scope, if such examination is to commence within one year before the date an HMO is to cease to provide services. In determining whether to waive the examination or reduce its scope, the Commissioner must consider the HMO's (a) claims payment history; (b) consumer complaint history with the department; (c) financial condition; and (d) compliance with Ark. Code Ann. § 23-76-118, which requires HMOs to make annual security deposits to protect enrollees against the HMO's insolvency. An HMO that requests a waiver must continue to make such security deposits until the HMO stops providing services in this state.
Ark. Code Ann. § 23-76-122.

Confidentiality of Medical Information

Information pertaining to the diagnosis, treatment or health of any enrollee is to be held in confidence and under state law, must not be disclosed to any person except on authorization of the enrollee, pursuant to statute or court order, or in the event of litigation between the enrollee and the HMO. The HMO is entitled to claim the same privileges against disclosure of patient information as would the provider under the same circumstances. The Health Insurance Portability and Accountability Act (HIPAA), the federal law on privacy of personal medical information, has further impacted confidentiality concerns.

Ark. Code Ann. § 23-76-129.

See HIPAA at page 115.

Powers

HMOs have the following powers: (1) to acquire and operate medical facilities, equipment and property as necessary to carry out the business of the organization; (2) to make loans to medical groups or to corporations under its control for the purpose of acquiring or constructing medical facilities and hospitals or in furtherance of a program providing health care services to enrollees; (3) to furnish health care services through providers that are under contract with the HMO; (4) to contract with persons to conduct marketing, enrollment, and administration on its behalf; (5) to contract with an insurance company licensed in this state, or with a hospital or medical service corporation authorized to do business in this state, for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the HMO; (6) to offer, in addition to basic health care services: (a) additional health care services; (b) indemnity benefits covering out-of-area or emergency services, and other special services; (c) indemnity benefits on a point-of-service basis within limits set by the Insurance Commissioner. ("Point-of-service" means indemnifying or paying for covered health care services that were received by an enrollee from providers not employed by or under contract with the HMO, or services obtained by enrollees from providers affiliated with the HMO but without proper referrals.); or (7) to contract with out-of-state providers who are licensed in the state in which the provider is located.

Before an HMO may exercise any of these powers, it must first obtain the Insurance Commissioner's approval by filing a notice with supporting documentation. The Commissioner may disapprove the exercise of the power on finding that it would adversely affect the financial soundness of the HMO, or that it would endanger the ability of the HMO to meet its obligations.

Ark. Code Ann. §§ 23-76-101 and following.

Prohibition Against Balance Billing

Health care providers who participate in HMO plans may not sue enrollees to collect sums owed by the HMO. Providers are further prohibited from demanding payment of such sums from enrollees or from making any statement to enrollees that would lead a reasonable person to believe that a demand is being made for payment of such sums.

Upon a provider's violation of this prohibition, the Commissioner will issue a written warning to the provider. The Commissioner is authorized to levy a fine between $150 and $1,500 against a provider who has a pattern or practice of violating the prohibition and continues to violate it after receiving the warning letter.

Ark. Code Ann. § 23-76-118(b).

Grievance and Quality Assessment Systems for Other Managed Care Organizations

Arkansas statutes provide for grievance and quality assessment systems for other managed care organizations. Those requirements are similar to the ones for HMOs. Specifically, the law makes it mandatory for all managed care health carriers and provider networks to have grievance and quality assessment systems. They must maintain records measuring the outcomes of health care services, and maintain quality assessment and improvement programs. They must submit to the Director of the Department of Health a written description of any quality assessment and improvement programs, and "[f]indings of relevant quality data as determined by the Director." Health carriers and networks must maintain records of grievances filed concerning the quality of health care services and submit a periodic report which includes a description of the process for resolving grievances, the total number of grievances handled, and the resolution of each grievance.

Ark. Code Ann. § 23-99-701 to 706.

Patient's Rights

A battle has been going on for several years over whether patients should be able to sue their health plans. In the typical malpractice case, the plaintiff can sue the doctor or hospital, but often the health plan is exempt. The reason is found in the federal Employee Retirement Income Security Act (ERISA). ERISA health plans have enjoyed the unusual benefit of immunity from state tort suits. An employee who has been wrongfully denied coverage for a certain benefit cannot sue under state law.

The employee must bring suit in federal court under ERISA, which offers only limited relief, *i.e.*, the employee is entitled only to the value of the denied benefits (at least as interpreted to date). A plan cannot be held liable for the injury or death that is caused to a patient by the denial of the benefits. Because ERISA plans provide health coverage for millions of Americans, this immunity has proved extremely controversial in the era of managed care.

For a number of years there was uncertainty in the courts as to whether managed care plans could be held liable for their decisions to deny benefits when such decisions resulted in harm to patients. Some states had passed laws to extend the scope of malpractice liability to include HMOs and other entities offering managed care plans. However, in 2004 in *Aetna Health Inc. v. Davila*, 542 U.S. 200, the United States Supreme Court said such state laws are preempted by ERISA, giving the insurance industry a unanimous victory and throwing the matter to Congress, which so far has failed to act.

See also, ERISA at page 91.

Genetic Nondiscrimination in Insurance Act

The Genetic Nondiscrimination in Insurance Act was enacted to prevent discrimination based on an individual's genetic makeup. The Act prevents an insurer from requiring or requesting that a person take a genetic test and conditioning the availability of certain kinds of insurance policies, such as disability, on this requirement. The Act prevents the insurer from making such a demand or request if the insurer does so to determine the person's eligibility for insurance coverage, to establish premiums, to limit or terminate coverage, or for the purpose of making any other such underwriting decision.

This prohibition against the use of genetic testing does not apply to life, disability income or long-term care insurance.
Ark. Code Ann. § 23-66-320.

See Genetic Information, Genetic Information Nondiscrimination Act of 2008 (GINA) on page 113.

JURY DUTY

Arkansas law does not exempt physicians from jury duty. The law provides that any person may be excused from jury duty, or may have service delayed to another time if, in the opinion of the court, such service will materially injure the person's own interests or the interests of the public.
Ark. Code Ann. § 16-31-103.

LASER SURGERY

The Arkansas State Medical Board's Regulation 22 regulates the use of medical lasers and appropriate delegation of tasks to non-physicians. Any physician who does not follow the standards set out in the regulation will be considered grossly negligent, and subject to discipline.

The regulation states that certain minor procedures and services may be delegated by the physician to appropriately trained non-physician office personnel, as long as the physician follows this protocol: (1) the physician must personally diagnose the patient's condition and prescribe the treatment and procedure to be performed; (2) the physician may delegate the performance of certain tasks in treatment only to trained non-physician personnel skilled in that procedure; (3) the physician must be available to respond to the patient should there be any complications from the minor procedure, and (4) the physician should document patient records that adequately describe the patient's condition, the procedure performed, and who performed the procedure.

The regulation states that a physician commits gross negligence if he performs laser surgery without the benefit of: (a) clinical experience in laser use; (b) training on clinical management of patients; (c) CME in the use of lasers, and (d) providing appropriate preoperative, operative and post operative management.
Arkansas State Medical Board Reg. 22.

LICENSING, PHYSICIAN

The Arkansas State Medical Board licenses the practice of medicine In 2009, the Arkansas General Assembly expanded the definition of "practice of medicine" to include the delegation of certain medical practices to other personnel. The new law then authorized the delegation of some

procedures and empowered the State Medical Board to enact rules on delegation.

The other portions of the definition of "practice of medicine" remain the same and include (1) holding out one's self as being able to diagnose, treat, palliate, prevent or prescribe for any human disease, ailment, deformity, injury or physical or mental condition by drugs, surgery, manipulation or other means; (2) advising or administering a form of treatment or healing for the cure of any disease, ailment, injury or physical or mental condition with the intention of receiving compensation; (3) maintaining an office or other place for treating or examining disease or injury; (4) using the title "M.D.", "M.B." (the British equivalent to an American "M.D."), D.O., "Physician," "Surgeon," or other word or abbreviation indicating the practice of medicine; or (5) performing any kind of surgery.

See also Delegated Medical Procedures at Page 63.

Ark. Code Ann. § 17-95-202, as amended Act 827 of 2007, as amended by Act 472 of 2007, as amended by Act 472 of 2009.

Osteopaths are licensed by the State Medical Board and are subject to the same licensing and examination requirements as medical doctors.

Ark. Code Ann. § 17-91-101 to 103.

Use of the Title "Doctor"

No person, in connection with the provision of health care services, is allowed to use, advertise, or call oneself, or allow oneself to be called by the title of "Doctor" unless use of that title is authorized under the Arkansas laws governing professions or unless the person has a doctoral degree in any healing arts profession and is licensed in that profession consistent with Arkansas law. In either case, use of the title "Doctor" must conform to the statutes and regulations governing the particular profession. "Healing arts" means the practice of a profession requiring special education and skill that promotes healing of the human body or that relates to the prevention of illness or disease.

Ark. Code Ann. §§ 17-80-109 to 113.

Exemptions

Certain acts do not require a license to practice medicine in Arkansas. Such acts include (1) gratuitous emergency aid; (2) occasional services rendered by an out-of-state physician; (3) the practice of Christian Science; (4) the performance of services by commissioned medical officers of the armed forces, Public Health Service, or Veteran's Administration; (5) nursing services performed by nurses; (6) services rendered by students, interns, and residents; (7) duties performed by a physical therapist or massage therapist; (8) practice of lay midwifery; (9) the practice of medicine by an employee of the Federal Bureau of Prisons, if such employee has a license to practice in Arkansas or in another state, territory, the District of Columbia, or Canada; the physician's duties are exempt only insofar as he provides services to inmates.

Ark. Code Ann. § 17-95-203.

Qualifications for Application

Applicants for a medical license must undergo state and federal criminal history background checks and must provide the board with a written authorization allowing it to view the criminal history reports. The process will include the Federal Bureau of Investigation taking the applicant's fingerprints.

Those seeking a license to practice medicine must file an application verified by oath with

the Arkansas State Medical Board. A licensing fee of $400 and documents, affidavits, and certificates in support must accompany the application.

No person will receive a license unless he or she meets the following requirements: (1) is 21 years of age; (2) has good moral character and has not been guilty of any act of unprofessional conduct as defined elsewhere in the statute; (3) has a degree from a recognized medical school; (4) if asked, can produce a verified certificate indicating one year of internship at an accredited hospital or a certificate confirming three years of internship or residency in an accredited postgraduate medical education program; (5) made a passing score on an examination approved by the board, and (6) has not pleaded guilty or nolo contendere or been found guilty of either a felony or "an infamous crime that would impact" the ability to practice medicine, regardless of whether the conviction has been sealed, expunged or pardoned. This requirement can be waived by the State Medical Board.

Slightly different requirements on internship and residency apply for those who graduated from certain foreign medical schools.

Ark. Code Ann. § 17-95-403; Ark. Code Ann. § 17-95-411; Ark. Code Ann. §§ 17-95-306 to 309.

Filing of Certificate

Once a certificate is received from the board, the physician must record the certificate in the county clerk's office where the physician proposes to practice. The certificate must be recorded again when the physician moves his or her practice to a new county.

Ark. Code Ann. § 17-95-407.

Annual Registration

The annual license renewal fee of $70.00 is due by the last day of the physician's birth month. The Arkansas State Medical Board will bill physicians 90 days before the birth-month deadline. Failure to pay the annual fee by the deadline leads to immediate suspension of the delinquent physician's license. Delinquent physicians may renew their licenses by paying all fees past due plus a $50 penalty. Failure to pay the annual fee for three consecutive years leads to automatic revocation of the delinquent physician's license.

A delinquent physician may apply for reinstatement of a revoked license. If the physician meets the moral character and professional qualification requirements needed for an original license, the board may reinstate the license.

Ark. Code Ann. § 17-95-408; Ark. Code Ann. § 17-95-411.

Perjury

Persons making false statements to the board about their qualifications commit perjury. They are subject to punishment as provided by law.

Ark. Code Ann. § 17-95-204.

License for Out-of-State Practitioners

Physicians legally licensed in another state may be issued a license to practice in Arkansas without examination at the board's discretion. The requirements for licensure in the other state must be equivalent to the licensure requirements of Arkansas. A licensure fee must be paid.

Ark. Code Ann. § 17-95-405.

Temporary Permits

Temporary permits may be issued by the board in two situations. First, the secretary of the board may issue a permit in "cases of emergency and to prevent hardship." The applicant must pay the standard fees and meet the standard qualification requirements. This type of temporary permit is only valid until the next meeting of the board. The board meets quarterly, in March, June, September, and December.

Second, the board may issue a temporary permit to a medical doctor qualified to practice medicine in the Philippines if the physician practices under the supervision of a regularly licensed physician. The holder of the temporary permit need not practice "out of the same office or in the same city or town" in which the supervising physician practices. This permit will not be valid for more than two years. If the person holding the temporary permit is not qualified for normal licensure at the end of two years, the board shall not extend the current permit or issue a new temporary permit.

Supervising physicians must notify the board in writing that they are supervising a holder of a temporary permit.

Ark. Code Ann. § 17-95-406.

Grounds for Denial, Suspension, or Revocation

The Arkansas State Medical Board possesses the power to refuse to issue a license or to suspend or revoke an existing license if the applicant or physician has exhibited unprofessional conduct or has run afoul of the license eligibility requirements.

The definition of "unprofessional conduct" was expanded in 2007 and 2009 to include (1) having been found in violation of a statute, rule or regulation governing the practice of medicine by a medical licensing authority in another state, and (2) committing an ethical violation of board rules. The other 17 parts of the definition remain the same and include (1) conviction of a crime of moral turpitude or conviction of a felony; (2) acts of fraud, misrepresentation, or deception in obtaining a license; (3) aiding or abetting the unlicensed practice of medicine; (4) procuring, or aiding or abetting the procurement of a criminal abortion; (5) violation of federal or state laws on the possession, distribution, or use of narcotics or controlled substances classed in Schedules I-V; (6) habitual alcohol abuse affecting skill and judgment; (7) grossly negligent or ignorant malpractice; (8) habitual or excessive use of narcotics or habit-forming drugs; (9) representing that an incurable condition can be permanently cured; (10) physical or mental incompetence endangering the public; (11) insanity or mental disease as determined by a legal proceeding or by voluntary commitment; (12) soliciting patronage, false advertising, advertising of quality of care, or advertising of illegal procedures; (13) offering, undertaking, attempting, or agreeing to directly or indirectly cure or prescribe for any condition by a secret method not divulged to the board; (14) willfully betraying a professional secret; (15) persistent, flagrant over-charging or over-treating of patients; (16) violating a board rule; (17) violating a term of probation or order previously imposed by the board. *Ark. Code Ann. § 17-95-409 as amended by Act 123 of 2007 and Act 1178 of 2009.*

Additionally, the board "may" suspend the license of a physician who breaches a contract to practice medicine in a rural area until the loan made to the physician as part of the contract is repaid in full. Certain circumstances may permit the board to waive such a suspension. *Ark. Code Ann. § 17-95-409, as amended by Act 1058 of 2007; Ark. Code Ann. § 17-95-306.*

Other restrictions on the eligibility for holding a license to practice medicine are based on the

individual's criminal record history. If a physician has pleaded guilty or nolo contendere, or has been found guilty of (1) an infamous crime that would impact his or her ability to practice medicine or (2) a felony, that person is not eligible to hold a license, regardless of whether the conviction has been sealed, expunged, or pardoned. However, the State Medical Board may waive this restriction after considering the following circumstances, including, but not limited to: (1) the age at which the crime was committed; (2) circumstances surrounding the crime; (3) the length of time since the crime; (4) subsequent work history; (5) employment references; (6) character references; and (7) other evidence demonstrating that the person does not pose a threat to the health or safety of the public. *Ark. Code Ann. §§ 17-95-307 to 308.*

The State Medical Board's Regulation 2 sets out other reasons to suspend or revoke a physician's license, including: (1) violations of laws, regulations or procedures on payments for medical services from public assistance or from insurers; (2) engaging in simultaneous sexual or romantic relationships with current patients, or in certain circumstances, with former patients; and (3) prescribing certain drugs, such as Talwin, Stadol, and Nubain for a non-terminal patient without cancer for more than six months without complying with certain record-keeping and other requirements set out in Regulation 2. Pursuant to Regulation 26, the board may suspend or revoke a license if a physician fails to obtain the appropriate informed consent for an abortion.

Proper Patient Relationships Prior to Treatment

The State Medical Board adopted minimum standards for establishing physician/patient relationships, as part of Regulation 2. A physician "exhibits gross negligence if he provides and/or recommends any form of treatment, including prescribing legend drugs, without first establishing a proper physician/patient relationship." Such a relationship, at a minimum, requires that the physician perform a history and physical adequate to establish a diagnosis, identify underlying conditions or contraindications to the treatment recommended or provided, (or that the physician personally knows the patient's health status through an ongoing personal or professional relationship) and that appropriate follow-up care be provided. For purposes of the Medical Board's regulation, a proper relationship is deemed to exist when: (1) treatment is provided in consultation with, or after referral by, another physician who has an on-going relationship with the patient and who has agreed to supervise treatment, follow-up care and use of prescribed medications or (2) in on-call or cross-coverage situations. Some situations are excluded from coverage by the rule: (1) emergencies where the life or health of the patient is in danger or imminent danger and (2) simply providing information of a general or generic nature not mean to be specific to an individual patient.

Patient Care and Electronic Means.

The AMA Code of Medical Ethics explains that "advisory services" by way of phone, fax or computer, "distinct from an existing patient-physician relationship" can be permissible as long as the physician does not make a clinical diagnosis, does not prescribe medication, and observes other safeguards outlined in AMA Code § 5.025.

On the use of e-mail, the AMA Code states that e-mail should not be used to establish a patient-physician relationship, but should supplement in-person visits with the patient. The physician must inform the patient of e-mail's inherent limitations, such as delays, breaches of privacy and confidentiality, and the patient must accept these limitations prior to the physician's communicating any privileged information. AMA Code § 5.026 sets out further restrictions on the use of e-mail.

On a related topic, the AMA states that physicians who are involved in health-related Internet sites should follow guidelines set out in AMA Code § 5.027. Such sites include interactive online ones where a physician provides advice to users with whom he does not have a pre-existing relationship.

Out-of-state physicians who, through the use of any medium including an electronic one, perform an act that is part of a patient care service initiated in Arkansas must be licensed by the Arkansas State Medical Board. Included are interpretation of an X-ray examination or preparation or interpretation of pathological material that would affect diagnosis or treatment. Licensure is not required for episodic consultation services, for services that are not available in Arkansas, or when the physician physically sees a patient in person in another state.
Ark. Code Ann. § 17-95-206.

See also Prescriptions, Internet and Electronic Mail Prescriptions at page 211.

Disciplinary Decisions

Any person may file a complaint against a physician. The complaint shall be filed with the State Medical Board. After conducting a hearing, the Medical Board determines whether the physician is guilty or not guilty of the charges against him. If the physician is found not guilty, the board will dismiss the charges. If the physician is found guilty, the board may either revoke his license, suspend the license for no longer than one year, issue a reprimand, or impose a probation allowing continuing practice under certain conditions. The board may additionally levy a fine of up to $1,000 per violation and collect out-of-pocket expenses incurred during investigation.
Ark. Code Ann. § 17-95-410.

Temporary Licenses

The State Medical Board may issue a twelve-month temporary license to practice medicine when needed in an area of critical medical shortage. The physician applying for a temporary license must meet the requirements for permanent medical licensure.

While physicians do not have to take a licensing examination, physicians of foreign medical schools must pass the Education Council for Foreign Medical Graduates examination.

Renewal of Temporary Licenses

A physician holding a temporary license seeking a renewal must submit a written request to the board and agree to continue to meet the requirements of temporary licensure. Further, the physician must agree to take an examination for licensure during the term of renewed temporary licensure.

A temporary license may not be held for a period exceeding three twelve-month terms. If the physician has yet to pass the examination for licensure, the board shall prescribe a plan of remedial training for the physician. The physician must complete any remedial training before receiving a regular license or another period of temporary licensure.
Ark. Code Ann. §§ 17-95-501 to 505.

Educational Licenses

Educational licenses to practice medicine are for physicians who are faculty members or who are under the supervision of faculty members at academic medical programs at the

University of Arkansas for Medical Sciences. The license, issued by the State Medical Board, authorizes the practice of medicine only within UAMS' clinical and educational programs. A physician applying for an educational license must meet the qualifications and requirements set out in the board's rules.

Educational licenses will be issued for a period of one year. Physicians who obtain educational licenses must comply with the same rules and laws as other licensed physicians in Arkansas.

Ark. Code Ann. § 17-95-412.

Unauthorized Practice of Medicine

Any person practicing or attempting to practice medicine without a license, if not exempted otherwise, shall be guilty of a misdemeanor. If convicted, the person shall be fined between $250 and $500, and may also be imprisoned from one to eleven months. Each day of illegal practice constitutes a separate offense.

Ark. Code Ann. §§ 17-95-401 to 402.

See also, Arkansas State Medical Board at page 39.

LICENSING, PSYCHOLOGISTS AND PSYCHOLOGY EXAMINERS

The Arkansas Psychology Board, formerly called the Arkansas Board of Examiners in Psychology, licenses psychologists and psychological examiners. The practice of psychology means the observation, description, evaluation, interpretation or modification of human behavior by a person holding an advanced graduate degree in psychology and who is trained in the application of psychological principles, methods or procedures for preventing or eliminating symptomatic, maladaptive or undesired behavior; enhancing interpersonal relationships, work and life adjustment, personal effectiveness, behavioral health and mental health; and consultation, teaching, and research. It includes, but is not limited to, administering and interpreting tests as well as diagnosing and treating mental and emotional disorders.

A person practices as a psychologist or as a psychological examiner by holding himself out to be a psychologist or a psychological examiner or by rendering to individuals or to the public for remuneration any services involving the practice of psychology.

Psychological examiners may independently provide services such as interviewing or administering and interpreting certain tests, but any other psychological services may be provided only under the supervision of a qualified psychologist. Except in neuropsychological and projective personality assessments, psychological examiners licensed before December 31, 1997 will be granted independent practice upon the Arkansas Psychology Board receiving a letter requesting independent practice and a revised statement of intent, without additional hours of clinical supervision. However, a psychological examiner licensed after December 31, 1997, is only allowed to practice independently, except in neuropsychological and projective personality assessments, if the person has completed a master's degree program in psychology, has completed 3,000 hours of approved clinical supervised training after making application for independent practice, and has filed a revised statement of intent, providing documentation of appropriate training and experience in areas requested for independent practice. In 2007, the

General Assembly passed a law stating that no new psychological examiner licenses will be issued after December 31, 2013.

Technicians employed by licensed psychologists in the practice of neuropsychology must be restricted to the administration and scoring of standardized objective tests. Only the supervising psychologist can select and interpret tests and communicate the results to the patient. The law sets out in detail the educational and other requirements for technicians, the supervisory requirements imposed on psychologists, and the responsibilities of both technicians and psychologists to patients. Additionally, psychologists must register each technician they employ with the Arkansas Psychology Board and must submit annual statements on how the technician is supervised.

Ark. Code Ann. § 17-97-102 to 103, as amended by Act 505 of 2007; Ark. Code Ann. § 17-97-201; Ark. Code Ann. § 17-97-401 to 405.

Qualifications for Application

One who wishes to obtain a license to practice as a psychologist or psychological examiner must apply to the Arkansas Psychology Board. To qualify for a license, the applicant must (1) be of good moral character; (2) have a doctoral degree (for psychologists) or a master's degree (for psychological examiners) in psychology or a closely related field from an accredited educational institution that the board deems satisfactory; (3) pass examinations administered by the board; (4) not be engaged in unethical practice; (5) have applied for a criminal background check and not been found guilty of or pleaded guilty or nolo contendere (no contest) to any of the offenses listed in Ark. Code Ann. § 17-97-312(f); and (6) not have failed an examination given by the board within the preceding six months. For certain serious criminal offenses, a person is permanently disqualifies obtaining a license even if the offense has been expunged. However, the new law clarifies that less serious offenses that have been expunged will not disqualify one from obtaining a license. Applicants for a psychologist's license also must have at least two years' experience, including one year of post-doctoral work.

The Arkansas Psychology Board may issue a "senior psychologist license" to an applicant who has: (1) at least twenty years of licensure to practice psychology in the United States or in Canada if that license was based on a doctoral degree; (2) received no disciplinary sanction during the entire period of licensure; (3) passed the Arkansas complementary examination, and (4) tendered the appropriate application and fees.

Ark. Code Ann. § 17-97-312(m); Ark. Code Ann. § 17-97-302.

Annual Registration

The Arkansas Psychology Board has the authority to adopt and enforce rules and regulations requiring licensed psychologists and psychological examiners to pay an annual registration fee in a sum to be fixed by the board, on a date fixed by the board. A license holder must complete forty hours of continuing education in the preceding twenty-four months in order to renew a license.

Failure to pay the annual registration fee on time results in automatic suspension of the license. Failure to pay the fee for three consecutive years will result in cancellation of the license, without hearing or notice. If the license is canceled, the license holder may apply for reinstatement, but the board will grant reinstatement only after considering the applicant's moral character and professional qualifications as if the applicant were filing an original application.

Ark. Code Ann. § 17-97-308.

Grounds for Denial, Suspension or Revocation

The Arkansas Psychology Board has the discretion to refuse to grant a certificate, to suspend or revoke a license, to impose a fine up to $5,000, to issue a letter of reprimand or require additional educational hours on any of the following grounds: (a) employment of fraud or deception in applying for a license or in passing the examinations to obtain the license; (b) practice of psychology under a false or assumed name or the impersonation of another practitioner; (c) habitual intemperance in the use of drugs or alcohol to such an extent as to render the licensee incapable of performing his duties; (d) violation of the Arkansas Medical Practices Act; (e) practice of a level of psychology inappropriate to the particular license; (f) recommendation of the ethics committee of the Arkansas Psychological Association or of the American Psychological Association; (g) negligence or wrongful actions in the performance of duties; or (h) violation of any of the board's rules or regulations or rules of ethics.

The board must refuse to issue or must revoke the license of a psychologist who has been found guilty of or pleaded guilty or nolo contendere to any of the offenses listed in Ark. Code Ann. § 17-97-312(f), unless the person requests and the board grants a waiver pursuant to Ark. Code Ann. § 17-97-312(h). For the serious offenses listed in Ark. Code Ann. § 17-97-312(m), any conviction or plea of guilty or nolo contendere, even if later expunged, will result in permanent disqualification for holding a license.

Ark. Code Ann. § 17-97-310, as amended by Act 827 of 2007; Ark. Code Ann. § 17-97-312.

Procedure for Denial, Suspension, or Revocation

The Arkansas Psychology Board is empowered to investigate any allegation or evidence that appears to show that a person, or anyone under a licensed person's supervision, is: (1) practicing psychology without a license, or (2) violating any of the rules and regulations adopted by the Board. Before the Board may take any action affecting a license, the Board must give the applicant or license holder at least twenty days' written notice and an opportunity for a hearing before the Board. Any disciplinary action affecting the license is subject to judicial review.

Ark. Code Ann. § 17-97-311.

Provisional Licenses

To apply for a provisional license, an applicant must (1) have received either (a) a doctoral degree in psychology from a regionally accredited educational institution or (b) its substantial equivalent from a regionally accredited educational institution; (2) have attained the age of majority; (3) have good moral character; (4) be physically and mentally competent to provide psychological services; (5) be free of any mental or physical disease or condition that would impair competency to provide psychological services; (6) not have been convicted of a crime involving moral turpitude or a felony; (7) not use drugs or alcohol to an extent that affects professional competency; (8) not have engaged in fraud or deceit in making the application; (9) not have aided or abetted another in falsely representing himself to be licensed to practice psychology; (10) not have falsely represented the applicant to be licensed; and (11) not have practiced psychology in this state without a license or without being exempt from the licensure requirements.

If the applicant meets those requirements, he may obtain a provisional license if he (1) passes the board's examinations; (2) satisfies the preliminary requirements of the laws on qualifications for applicants for a psychologist's or psychologist examiner's license.

One who holds a provisional license may practice psychology under the supervision of a licensed psychologist.
Ark. Code Ann. § 17-97-305.

Unauthorized Practice of Psychology

A person who holds himself out as practicing psychology is guilty of a violation if he does not possess a valid license. A fine of at least $500 and no more than $1,000 accompanies the conviction of this violation.
Ark. Code Ann. § 17-97-301.

LONG-TERM CARE FACILITIES

Long-term care facilities include any building or institution for the accommodation, board, care or treatment of more than three unrelated individuals who, because of age or any infirmity, are unable to sufficiently care for themselves, and where a charge is made for the accommodation, board, care or treatment. The term includes nursing homes, residential care facilities, assisted living facilities, and adult day cares. However, the definition does not include the following: (1) offices of private physicians and surgeons; (2) hospitals; (3) recuperation centers; (4) supervised or supported living apartments, group homes, family homes, or developmental day treatment clinics; (5) institutions operated by the federal government; (6) separate living arrangements not involving monitoring the residents, or (7) hospices. The definition of "long-term care facility" no longer expressly excludes "boarding homes with fifty percent or more of the residents not receiving personal care as defined by Arkansas Medicaid regulations."
Ark. Code Ann. § 20-10-213.

See also Abuse, Maltreatment of Adult at Page 23; Reporting, Mandatory Physician, Abuse of Endangered or Impaired Persons or Long-Term Care Facility Residents at page 217.

MALPRACTICE

Informed Consent

Informed consent is important as a matter of physician treatment. When a physician treats a patient without first obtaining consent, a battery occurs. Battery is a civil tort for which the physician may be held liable for monetary damages. By contrast, malpractice occurs when the physician has obtained consent, but the consent is not "fully informed."

See Gastric Bypass Consent at page 113.

Who May Consent

The following persons are authorized to consent to medical or surgical treatment prescribed or recommended by a licensed physician: (1) adults for themselves, or married minors for themselves; (2) emancipated minors, for themselves; (3) unemancipated minors of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment for themselves (*See Mature Minor Doctrine, this section below*); (4) parents for their minor child, or adult child of unsound mind (The meaning of "child" includes adopted children, step-children, and foster or pre-adoptive children who are not in custody of the state Department of Human Services. The father of an illegitimate child cannot consent for treatment solely on the basis of parenthood.); (5) females regardless of age, for themselves when given in connection with pregnancy or childbirth (for example, prenatal exams), except for abortion; (6) persons standing in *loco parentis* (parental role) whether serving formally or not, and guardians, conservators, or custodians, for their ward or other charge under disability; (7) adults for their minor sibling or adult sibling of unsound mind; (8) grandparents, in the absence of an authorized parent for their minor grandchild or adult grandchild of unsound mind; (9) married persons for a spouse of unsound mind; (10) adult children for their mother or father of unsound mind; and (11) minors, for themselves, incarcerated in the Department of Correction or Department of Community Punishment.

Act 700 of 2009 clarified who may consent to medical care for foster and pre-adoptive children who are still in the custody of the Department of Human Services. Any foster parent or pre-adoptive parent for a child in the custody of DHS may consent to emergency treatment, routine medical treatment, ongoing medical treatment, and nonsurgical procedures provided by either a primary care provider or a specialty care provider. DHS must be given timely notice of all treatments consented to by such parents.

Consent of a DHS representative is still required for nonemergency surgical procedures, nonemergency invasive procedures, "end of life" nonemergency procedures such as do-not-resuscitate orders, withdrawal of life support, and organ donations, and nonemergency medical procedures relating to a criminal investigation or judicial proceeding that involves gathering forensic evidence.

An "unsound mind" means the inability to perceive all relevant facts related to one's condition and proposed treatment so as to make an intelligent decision on treatment. The disability may be temporary or even intermittent. It may be caused by the patient's natural condition, age, shock or anxiety, illness, injury, drugs or sedation, intoxication, or other causes.
Ark. Code Ann. §§ 20-9-601 to 602, as amended by Act 700 of 2009; Ark. Code Ann. § 20-16-803.

Divorced or Separated Parents and Authority to Consent to Treatment.

The parent with legal custody of a child generally is the only parent who has the authority to make medical decisions. (Note that different rules apply when a minor seeks to have an abortion. **See Family Planning, Abortion, Parental Consent Requirements at page 98.**) The authority to make medical decisions will be given in a temporary order, divorce decree, custody order, temporary order of protection, or permanent order of protection. The most prudent method to determine who has the authority is to obtain a copy of the *most recent* order granting custody and have the document reviewed by legal counsel.

"Legal custody" can be expressed different ways in the various orders, using terms such as: *sole custody, physical custody,* or *joint custody with the child's primary residence with one parent.* Sometimes parents agree, or the judge orders the parents, to have equal decision-making ability. This will be written in the decree or custody order using phrases such as: *joint legal custody, each parent has equal access to all medical care providers and medical records, no elective treatment will be done without both parents' consent.* There are various degrees of authority that might be ordered or agreed upon, such as: *No elective surgery without first notifying the non-custodial parent; no surgery without the consent of both parents; emergency medical treatment only.*

If there is a dispute between parents who have joint legal custody and who have no restrictions on medical treatment decision-making, treatment can be provided at the request of one of the parents.

It is important to realize that one parent initially may have been granted custody in the divorce decree, but a later court order could have changed the custody arrangement. The Circuit Clerk's office of the county in which the divorce was granted generally will have copies of all the decrees, judgments, and orders filed in a divorce. The most recent custody order is the governing one. If both parents have moved from the county in which the divorce was granted, the file may be transferred to the county or state where the custodial parent lives. If one parent has custody under an Order of Protection, either temporary or permanent, no divorce may ever have been filed, or the parents may not be married.

Unmarried Parents and Authority to Consent to Treatment.

The mother has sole custody and legal decision-making power in families whose parents have never married. However, if the father has a court order recognizing his paternity, then the same rules apply as with divorced or separated parents.

Maltreated Adults and DHS Authority to Consent to Treatment.

The Adult Maltreatment Custody Act of 2005, permits the state Department of Human Services to be court-appointed as the legal custodian of a "maltreated adult" as defined by that law. Once DHS obtains a court appointment as the custodian, it may consent to certain kinds of medical care for the maltreated adult. However, DHS may not consent and must obtain "express court approval" for the following: abortion, sterilization, psychosurgery, or removal of bodily organs "unless a procedure is necessary in a situation threatening the life of the maltreated adult"; the withholding of life-saving treatment; use of experimental medical procedures, or amputation. DHS may not be appointed custodian of an adult for the sole purpose of providing consent to medical treatment. No mentally competent person will be placed in DHS' custody for protection from domestic abuse. DHS is prohibited by the law from becoming the custodian of a maltreated adult who is in need of acute psychiatric treatment, chronic mental health treatment or

alcohol or drug abuse treatment.
Ark. Code Ann. §§ 9-20-101 and following, as amended by Act 529 of 2009.

See also, Abuse, Maltreatment of Adults at page 23; Mandatory Reporting, Abuse of an Adult at page 216.

Implied Consent

An implied consent is presumed when an emergency exists and there is no one available who is authorized to give consent. An "emergency" exists when, in competent medical judgment, the proposed surgical or medical treatment is immediately necessary and any delay occasioned by an attempt to obtain a consent would reasonably be expected to jeopardize the life, health, or safety of the patient, or reasonably would be expected to result in disfigurement or impaired faculties.

An implied consent is further presumed when an emergency exists, and the person authorized to consent has refused to give consent, no other person authorized to give consent is immediately available, and the patient subsequently has suffered a material and morbid change in condition.
Ark. Code Ann. § 20-9-603.

Court's Consent

Consent may be given by the court when an emergency exists and those authorized to give consent refuse to do so. The provider must submit a petition to the court with the physician's written declaration that in his professional opinion, there is an immediate or imminent necessity for medical or surgical treatment. If the medical provider so requests, the prosecuting attorney or his designee must assist in the presentation of the petition and in obtaining the order from the court.

The judge may order the necessary treatment, provided that the patient is (1) a pregnant female in the last trimester of pregnancy; (2) a person of insufficient age or mental capacity to understand and appreciate the nature of the proposed treatment and the probable consequences of refusal of the treatment; or (3) a parent of a minor child when the court finds that the life or health of the parent is essential to the child's financial support or physical or emotional well being. The judge who makes this decision is immune from liability based on a claim that the medical or surgical treatment should not have been given.

The reasonable costs of the emergency medical and surgical services are the responsibility of the patient's estate or any person liable at law for the patient's care. If they are unable to pay, then the county of the patient's residence becomes responsible.
Ark. Code Ann. § 20-9-604.

Content of Informed Consent

The content of a reasonable informed consent includes the patient's diagnosis, nature of the contemplated procedure, risks involved, probability of the procedure's success, risks of foregoing the procedure, and existence of any alternatives to the procedure.

The standard of care for informed consent in Arkansas places on the physician a duty to provide information regarding the treatment, procedure, or surgery as would customarily have been given by other medical care providers with similar training and experience at the time of the treatment, procedure, or surgery in the locality in which the physician practices or in a similar locality.
Ark. Code Ann. § 16-114-206.

See Family Planning, Abortion, at page 93; Gastric Bypass Consent at page 113.

Mature Minor Doctrine

The mature minor doctrine is an exception to the rule requiring prior parental consent for the medical treatment of a minor. Therefore, in assessing a minor's ability to consent, physicians must adequately consider such factors as the minor's age, ability, experience, education, training, and degree of maturity or judgment at the time of the proposed treatment. However, under Arkansas law, consent of a parent, guardian or legal custodian is required before a minor may have an abortion, with some exceptions. ***See Family Planning, Abortion, Parental Consent Requirement at page 98.***

Physicians have an ethical duty to promote autonomy of minor patients by involving them in medical decisions to an extent commensurate with their maturity. When the competent minor does not wish to involve his parents, the physician may accept his consent for treatment. The physician should encourage the minor to involve his parents, but the physician may not do so himself. The physician may determine the minor's competence, but when necessary, the physician may consult an expert in adolescent medicine.

AMA Code of Medical Ethics, § 5.055; Ark. Code Ann. § 20-16-801 and following, as amended by Act 758 of 2009.

See also Sexually Transmitted Diseases, Consent of Minors at page 233; HIPAA at page 115; Laser Surgery at page 145.

Malpractice Actions

A "medical injury" which poses a threat of malpractice is defined as any adverse consequence resulting from the provision of service by a medical provider. Malpractice actions are grouped into five classifications: (1) acts of negligence, error, or omission; (2) failure to obtain informed consent, or a breach of warranty or contract; (3) failure to diagnose; (4) abandonment of a patient or premature cessation of treatment; (5) failure to properly maintain equipment; and (6) any other acts during the course of service that cause injury.

Statute of Limitations

Malpractice plaintiffs have two years from the date of the alleged wrongful act to bring suit. This rule has been strictly followed, except under two circumstances.

First, if the action is based on the discovery of a foreign object in the body of the injured person, the action may be brought within one year from the date of discovery or the date the foreign object should reasonably have been discovered, whichever is earlier.

The second exception applies to injured minors and has two parts. If the child was nine years of age or younger when the malpractice occurred, then the malpractice action may be brought anytime within the later of the child's eleventh birthday or two years from the date of the act complained of. However, if the medical injury is not known nor could it have been discovered by the child's eleventh birthday, then the malpractice action may be brought within two years after the medical injury is known or reasonably could have been discovered, or the minor's nineteenth birthday, whichever is earlier. *Ark. Code Ann. §16-114-203.*

The statute of limitations described above is qualified by the doctrine of continuing care. This doctrine holds that the statute of limitations temporarily stops running during the period that

the patient is under continuing care by a doctor having a duty to continue care. An exception to this doctrine occurs when the patient either learns of negligence or should have learned of negligence (constructive knowledge) while undergoing continued care. In this case, the malpractice action must be brought within two years of the time of discovery, actual or "constructive". The doctrine of continuing care has been applied very narrowly and requires more than just an ongoing physician-patient relationship. Rather, the patient must be under an active, continuing course of treatment in order for this exception to apply. *Taylor v. Phillips, 304 Ark. 285, 801 S.W.2d 303 (1990).*

Tolling of the Statute of Limitations

Changes to the law in 2003 extended the statute of limitations if certain requirements are met. The statute of limitations will be extended 90 days, if within 30 days prior to the expiration of the applicable statute of limitations, an appropriate written notice of intent to sue for medical injury is served on the medical care provider alleged to have caused the injury. The written notice must meet the following requirements: (1) It must be served by certified mail, return receipt requested; (2) it must include: (a) the claimant's name, date of birth, present address and address at the time of treatment at issue and social security number; (b) the dates of the treatment in question and a summary of the alleged wrongful conduct, and (c) the names and addresses of the known medical care providers relating to the alleged injury; and (3) it must include an authorization to release medical records signed by the claimant, which will permit the provider alleged to be liable to obtain pertinent medical records.

Failure to comply with any of the requirements will result in the statute of limitations not being extended for the 90-day period.

If a request for production of medical records accompanies the written notice of intention to file an action for medical injury and if copies of the medical records are not provided to the claimant within 30 days of the provider's receipt of notice, then the claimant may file an independent expedited declaratory judgment action seeking a declaration that the medical care provider failed to produce the medical records within the required 30-day period. If the court finds that the medical records were not produced as required, the statute of limitations will be extended for a period of 75 days from the date of the production of the medical records. If the court finds that the failure to produce copies of the medical records is without good cause, the court shall award the claimant his reasonable costs and attorney's fees for the declaratory judgment action.
Ark. Code Ann. §16-114-212.

Notice of Intent to Sue

Prior to 1995, all plaintiffs (claimants) were required to give notice of intent to sue to providers within 60 days of filing suit. This requirement was eliminated by court decision, and consequently, notice of intent is no longer required, except as specified above to extend the statute of limitations. Yet, many plaintiffs still follow this old procedure.

Allegation of Damages

In the complaint, the plaintiff must not specify the amount of damages claimed. Instead, the plaintiff must only make a general allegation of damages, and then state that damages are within the jurisdictional limits of the court. The defendant may then demand, by special interrogatory, a statement of the amount of damages claimed by the plaintiff. The plaintiff must respond to the

interrogatory within 30 days. *Ark. Code Ann. § 16-114-205.*

Venue

Any action for medical injury against a medical care provider must be filed in the county in which the alleged act or omission occurred.
Ark. Code Ann. § 16-55-213.

Expert Affidavit

In 2003, the legislature created the requirement that in all medical malpractice cases where expert testimony is required, an affidavit supporting the malpractice claim, and signed by an expert who engages in the same type of medical care as the medical care provider defendant, must be filed with the court within 30 days after the complaint is filed. *Ark. Code Ann. §16-114-209.* However, in 2007, the Arkansas Supreme Court struck down the portion of the law requiring the affidavit to be filed within 30 days to avoid automatic dismissal of the case. *Summerville v. Thrower*, *369 Ark. 231, 253 S.W.3d 415 (2007).* The practical effect has been that expert affidavits are not promptly filed by plaintiffs, and unless the defendant insists on the filing, some plaintiffs never file the affidavit.

Burden of Proof

Specific kinds of expert testimony are required if the negligence alleged was not a matter of common layperson knowledge. In a malpractice action, when the asserted negligence does not lie within the jury's comprehension as a matter of common knowledge, the plaintiff has the burden of proving the following: (1) by means of expert testimony provided only by a medical care provider of the same specialty as the defendant "the degree of skill and learning ordinarily possessed and used by members of the profession of the medical care provider in good standing, engaged in the same type of practice or specialty in the locality in which he practices or in a similar locality; (2) by means of expert testimony provided only by a medical care provider of the same specialty as the defendant that the medical care provider failed to act within that standard; and (3) by means of expert testimony provided only by a qualified medical expert that, as a proximate result thereof, the injured person suffered injuries which would not otherwise have occurred.

When the plaintiff claims that a medical care provider failed to give adequate information to obtain informed consent, the plaintiff carries a special burden of proof. The plaintiff must prove: (1) that the service was rendered in other than an emergency situation and (2) that the medical care provider did not supply that type of information as would customarily have been given by other medical care providers with similar training and experience in the locality in which the medical care provider practices or in a similar locality.

The medical care provider may offer any of the following defenses to an allegation of failure to provide adequate information for an informed consent:

1. A person of ordinary intelligence and awareness in a position similar to that of the injured person could reasonably be expected to know the risks inherent in the treatment, procedure, or surgery.
2. The person giving consent knew of the risks inherent in the treatment, procedure, or surgery.
3. The injured person would have undergone the treatment, procedure, or surgery

regardless of the risk involved.

4. The injured person did not wish to be informed.
5. It was reasonable for the medical care provider to limit disclosure of information because disclosure could be expected to adversely and substantially affect the injured person's condition.

Ark. Code Ann. §16-114-206.

Provider's Testimony

No medical care provider shall be required to give expert opinion testimony against himself or herself as to the appropriate standard of care at a trial. However, this prohibition does not apply to discovery. Discovery information can be used at a trial as in other lawsuits.

Compensatory Damage Awards

Damage awards in a medical malpractice case are calculated as to past and future economic losses and non-economic losses such as pain and suffering. Economic losses are composed of such items as the cost of reasonable and necessary medical services, rehabilitation services, custodial care, loss of services, and loss of earnings or earning capacity. *Ark. Code Ann. §16-114-208.*

A state law passed in 2003 provided that any evidence of damages for the costs of any necessary medical care, treatment or services received shall include only those costs actually paid by or on behalf of the plaintiff or which remain unpaid and for which the plaintiff or any third-party shall be legally responsible. *Ark. Code Ann. § 16-55-212.* However, that provision was declared unconstitutional in 2008. Now the full amount of costs incurred are presented to the jury for consideration as damages. The costs are not reduced to reflect any payments from other sources, except in a few limited circumstances. *McMullin v. U.S., 515 F. Supp.2d 904 (2007); Burns v. Ford Motor Co., 549 F. Supp.2d 1081 (2008).*

If the plaintiff wins, the jury must specify separately its award for past and future economic losses and its award for past and future non-economic losses. In the event the plaintiff prevails with an award for future damages in excess of $100,000, the court shall, if requested by either the plaintiff or the defendant, order that future damages be paid in whole or part by periodic payments, rather than a lump sum payment. Should the court order periodic payments, it may also order terms and conditions it deems just and equitable to protect the plaintiff's right to future payment of damages.

If the injured person dies before the completion of installment payments of principal and interest, either party may request that the court subtract out amounts for future pain and suffering and future expenses of care, and then pay the remainder to the estate of the decedent.

Ark. Code Ann. §16-114-208.

Standard for Award of Punitive Damages

To recover punitive damages, the plaintiff must prove: the defendant is liable for compensatory damages; and (1) the defendant knew or ought to have known, in light of the surrounding circumstances, that his conduct would naturally and probably result in injury and that he continued the conduct with malice, or in reckless disregard of the consequences, or (2) that the defendant intentionally pursued a course of conduct for the purpose of causing injury.

Ark. Code Ann. §16-55-206.

Burden of Proof for Award of Punitive Damages. The plaintiff has the burden of proof in proving punitive damages by "clear and convincing evidence", which is a higher legal standard that the "preponderance of the evidence" standard usually applied in civil cases.
Ark. Code Ann. § 16-55-207.

Limitations on the Amount of Punitive Damages. The general rule is that punitive damages shall not be more than the greater of $250,000 or three times the amount of compensatory damages awarded, not to exceed $1,000,000. The limitation does not apply where the defendant is found to have intentionally pursued a course of conduct for the purpose of causing injury or damage and where the conduct did in fact harm the plaintiff. The limits on punitive damages are adjusted at three-year intervals, beginning in 2006, in accordance with the Consumer Price Index. This cap on damages applies to each plaintiff in a suit, not to the judgment of the court in one case.
Ark. Code Ann. § 16-55-208.

Bifurcated Proceeding. In any case where punitive damages are sought, any party may request a bifurcated proceeding at least ten days prior to trial. If a bifurcated proceeding has been properly requested by any party, then the fact finder must first determine whether compensatory damages are to be awarded and then shall determine whether and in what amount punitive damages will be awarded. Evidence of the financial condition of the defendant and other evidence relevant only to punitive damages is not admissible with regard to any compensatory damage determination.
Ark. Code Ann. § 16-55-211.

Joint and Several Liability.

Liability of each defendant for compensatory and punitive damages shall be "several" (separate) only and shall not be joint. Each defendant shall be liable only for the amount of damages allocated to that defendant in direct proportion to that defendant's percentage of fault, and a separate several judgment shall be rendered against the defendant for that amount. To determine the amount to be paid by the defendant, the court shall multiply the total amount of damages by the percentage of each defendant's fault, and that amount shall be the maximum recoverable against that defendant. Prior to changes to the law in 2003 as part of tort reform, there was joint and several liability in medical malpractice cases, which meant that if one defendant were bankrupt and another defendant were solvent, the plaintiff would be able to recover all his damages from the solvent defendant.
Ark. Code Ann. § 16-55-201.

Assessing Percentages of Fault. The 2003 tort reform law provided that the fact-finder, which in medical malpractice cases is usually a jury, must consider the fault of all persons or entities who contributed to the alleged injury or death, regardless of whether the person or entity was a party to the lawsuit. *Ark. Code Ann. § 16-55-202.* However, that provision was found unconstitutional in 2009. *Johnson v. Rockwell Automation, 2009 Ark. 241.* As a result, fault is assessed among the defendant(s) and the plaintiff only. The law of "comparative fault" provides that a plaintiff may not recover any amount of damages if the plaintiff's own fault is determined to be fifty percent or *greater.*
Ark. Code Ann. §16-55-216.

Percentages of Fault May Be Increased to Ensure Collection. If separate "several" judgments have been entered against multiple defendants, a plaintiff may, no later than ten days after the entry of judgment, ask the court to determine whether the plaintiff's recovery of compensatory damages will not be reasonably collectible. If the court determines that any defendant's several share or multiple defendant's several shares will not be reasonably collectible, the court shall increase the percentage points of the several shares, subject to certain limitations. The ability of the court to increase a defendant's share applies only to compensatory damages, not to punitive damages.

If a defendant's percentage of fault is determined to be ten percent or less, then the percentage points of that defendant's share shall not be increased. If the defendant's percentage of fault is greater than ten percent, but less than fifty percent, the defendant's several share shall be increased by no more than ten percentage points. If a defendant's percentage of fault is fifty percent or greater, then the percentage points of that defendant's share shall be increased by no more than twenty percentage points.

Under no circumstances shall the combined percentage points of the remaining defendants' several shares exceed the lesser of one hundred percentage points or the total number of percentage points remaining after deducting the percentage of fault of the plaintiff, if any. Any defendant whose several share has been increased and who has paid the increased share may sue the non-paying defendants whose shares were determined by the court to be not reasonably collectible.

Ark. Code Ann. §16-55-203.

No Percentage Increase for Long-Term Care Facility Medical Directors. If a medical director of a long-term care facility is sued only in his capacity as director, the provisions of the law that allow for a percentage increase shall not apply to him or her.

Ark. Code Ann. §16-55-204.

"Acting in Concert" or as Agent

As applied to the malpractice setting, the law would permit a defendant to be held liable for the conduct of someone else if malpractice were *intentional*. Of course, this is virtually never the case. Under this provision, a defendant can be responsible for the fault of another person or entity, or for the payment of the proportionate share of another person or entity, if both the defendant and the other person or entity were "acting in concert" or if the other person or entity was acting as an agent or servant of the defendant. "Acting in concert" means entering into a "conscious agreement to pursue a common plan" to commit" intentional harm to someone. Negligent acts are not covered by the "acting in concert" law.

Ark. Code Ann. §16-55-205.

Notice of Malpractice Claim

Duty to Report

Any physician receiving notice of a malpractice claim or lawsuit against him must notify the State Medical Board within ten days of receiving notice. The report must be sent by registered mail, made on the board's approved forms, and contain a copy of the complaint if a lawsuit has been filed. Filed reports constitute privileged information not open to the public except on court order. *Arkansas State Medical Board Regulation 23, Ark. Code Ann. § 17-95-103.*

Mediation

All Arkansas circuit courts and appeal courts have the power to order litigants in civil cases to go through mediation. Medical malpractice cases are among the kinds of cases that a circuit court could force to go to mediation.

Mediation is one kind of dispute resolution process that is an alternative to a trial or further court proceedings. In mediation, a neutral third party, who is often a professional mediator, is hired by the parties to assist them in negotiating a settlement acceptable to the parties. The mediator does not act as a judge; he or she is powerless to impose an agreement.

Under the law, if a case is ordered to mediation by the court, the parties must choose a mediator who either meets the requirements set out by the Arkansas Alternative Dispute Resolution Commission or is approved by the court to mediate their case. If a party is unable to pay the costs of mediation, it may ask the court to rescind the order to mediate.
Ark. Code Ann. § 16-7-202.

See also, Subpoenas at page 235.

Medical Malpractice Insurance

In 2009, the General Assembly changed the state's general insurance law to allow medical malpractice insurance to be covered by certain requirements that govern property and casualty insurance on commercial risks. Previously, medical malpractice insurance had been specifically exempted from these requirements. The expansion of the law to include medical malpractice policies imposes minimum insurance policy requirements and provides some consumer-type protection to physicians.

Under the general commercial risks requirements, insurers and insurance policies must meet standards for policies in general and meet certain requirements for claims-made policies. The mandatory provisions include ones on advance notification of premium increases, mandatory extension or renewal of policies in certain circumstances, and extended reporting periods for claims-made policies.
Ark. Code Ann. §§ 23-79-301 to 310, as amended by Act 726 of 2009.

MEDICAID

Provider Enrollment

Medicaid is a jointly funded state and federal program for low-income persons. It is administered by the states under the direction of the federal government. Physicians (M.D.s and osteopaths) enroll in Medicaid by completing an application, a provider contract and other forms. Upon approval by the Enrollment Contractor, the physician is assigned a "provider number." This number must be used on all claims and correspondence submitted to Arkansas Medicaid. The physician's eligibility is retroactive one year from the date the Division of Medical Services of the Arkansas Department of Human Services ("DHS") approved the agreement, the effective date of the provider's license or certification, or the date the service became a part of the Arkansas Medicaid Program, whichever date is the most recent. Providers may enroll online at www.medicaid.state.ar.us or they may mail printed forms to Medicaid Provider Enrollment Unit,

EDS, P.O. Box 8105, Little Rock, AR, 72203-8105.

Arkansas Medicaid Physician Provider Manual § I-141.000 (Rev. 09-2009).

Participation in the Arkansas Medicaid program is subject to the rules and regulations contained in the Medicaid Physician Provider Manual. This manual is an important source of information and should be consulted for detailed participation rules. Provider manuals, updates, and official notices can be downloaded without charge at: www.medicaid.state.ar.us. The manual is divided into five parts: Section I, general information about the Medicaid program and the role and responsibilities of providers and beneficiaries; Section II, specific rules applicable to physician services; Section III, general procedures for billing; Section IV, glossary of terms; and Section V, forms and Internet links.

Conditions of Participation

Payment in Full

Among the several enumerated conditions for participation, the physician must agree to accept payment from Medicaid as "payment in full" for covered services. This means that the physician may not collect the excess of his/her charge over the Medicaid payment from the patient. However, patients may be billed for co-pays or cost-sharing allowed under Medicaid.

Arkansas Medicaid Physician Provider Manual § I-142.200 (Rev. 09/2009); -132.000 (Rev. 09/2008).

Fee Schedule

Medicaid reimburses most physicians for services based on a fee schedule set by a judicial consent decree negotiated by the Arkansas Medical Society. Under the fee schedule, reimbursement is based on the lesser of the billed charge for the procedure or the maximum allowable for the procedure. The maximum allowable amount for a particular procedure is the same for all physicians regardless of specialty. Medicaid now publishes its physician fee schedule online at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/physicn.aspx.

Arkansas Medicaid Physician Provider Manual §§ II-271.000; -272.830 (Rev. 10/2003, 03/2005).

Discounts (Customary Charge)

According to the Medicaid Physician Provider Manual, physicians must bill Medicaid patients their lowest charge, including discounts. "A discount is defined as the lowest available price charged by a provider to a patient or third party payor, including any discount, for a specific service during a specific period of time by an individual provider. If a Medicaid provider offers a professional or volume discount to any patient, the same discount must exist for claims submitted to Medicaid."

Arkansas Medicaid Physician Provider Manual § IV-400.000 (Glossary)(Rev. 02/2008).

Medical Necessity

All Medicaid benefits are based on "medical necessity." Thus, Medicaid may deny payment if it determines the service is not medically necessary, or is generally regarded by the medical profession as experimental or unacceptable. "Medically necessary" means the service "is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or injury, threaten to cause or aggravate a handicap or cause physical deformity or malfunction and if there is no other

equally effective . . . course of treatment available or suitable for the beneficiary requesting the service."

Arkansas Medicaid Physician Provider Manual § IV-400.000 (Glossary) (Rev. 02/2008).

Payor of Last Resort

Medicaid is the payor of last resort. Medicaid may supplement other insurance, but it may never supplant it. Patients covered by Medicaid have impliedly authorized medical care providers and insurance companies to release information to DHHS so that DHHS may enforce its rights as assignee.

Ark. Code Ann. §§ 20-77-101, 306, 308.

Record Keeping Requirements

Providers are required to keep accurate and complete original medical records that explain all care, diagnoses, and other activities in connection with the Medicaid beneficiary. If a provider maintains more than one office in the state, the provider must designate one office as the home office, where original records must be stored. Records must be retained for at least five years or until all audit questions or review issues are concluded. Providers must furnish all original records to authorized Medicaid representatives or other law enforcement agencies. If the records are stored off-site, the provider may have three days to make the records available.

Arkansas Medicaid Physician Provider Manual § 142.300 (Rev. 09/2009).

Disclosure Requirements

As a condition of participation in the Medicaid program, providers must disclose certain information regarding the persons and/or parties that hold direct or indirect ownership in the provider, including the identity of any such person who has been convicted of a criminal offense. Also, a provider must disclose any ownership of a subcontractor with whom the provider has business transactions totaling more than $25,000 or five percent of the provider's total operating expenses during the 12-month period preceding the date of application or application renewal.

Arkansas Medicaid Physician Provider Manual §§ 142.410 - 142.430 (Rev. 09/2008).

Grounds for Sanctioning Physicians

Grounds

Physicians may be sanctioned for fraudulent and abusive practices, including submitting inaccurate, false or fraudulent claims for care, services, or merchandise; submitting information with the intent to obtain greater compensation than the provider is entitled to, as in billing for services at a higher level than were actually provided, or by charging Medicaid patients more than other patients receiving the same service; over-utilizing the Medicaid program by delivering merchandise or services that are not medically necessary; accepting a fee for a Medicaid patient referral; accepting Medicaid payment and then collecting additional payment from the patient or responsible person; or billing Medicaid for services prior to the delivery of those services. Physicians also may be sanctioned if they have been formally reprimanded or censured by a licensing, certifying or accrediting entity or if they are suspended, terminated or excluded from participation in another government program.

Arkansas Medicaid Physician Provider Manual § I-151.000 (Rev. 09-2009).

Sanctions

Upon a finding of grounds, physicians may be subject to various sanctions. These sanctions include suspension or termination from participation in the Medicaid Program; denial or recovery of payments that Medicaid made to the physician; attendance at provider education sessions; imposition of prior authorization of services; 100% review of claims prior to payment; referral to the State Medical Board for investigation; referral to the state Attorney General's Medicaid Fraud Division; or prosecution under applicable federal or state laws, which may result in recoupment under civil suit with penalties, or fines and imprisonment if criminal charges are filed.

Arkansas Medicaid Physician Provider Manual § I-152.000 (Rev. 09/2009).

Claims Review Procedure

Administrative sanctions are available against health care providers who attempt to obtain payments to which they are not entitled. The Director of the Department of Human Services is authorized under the law to set up a procedure to review claims by health care providers to determine if the claim should be or should have been paid. The review may come before or after payment is made to a health care provider. The Director can withhold payment to a health care provider during a claims review if "necessary to protect the fiscal integrity of the medical assistance programs"; however, the health care provider must have an opportunity for a hearing within sixty days of the date payment is withheld. A health care provider who receives an administrative sanction may request a hearing to contest the sanction, and if not cleared, the person may seek judicial review.

Ark. Code Ann. §§ 20-77-1301 to 1305.

See also, Fraud and Abuse at page 101.

Medicaid Primary Care Case Management Program

Medicaid operates as a managed care program. As such, Medicaid recipients select a primary care physician (PCP) who agrees to provide, through an ongoing relationship, primary care services to the recipient, and to refer the recipient for all necessary specialty services and hospital care. With a few exceptions, patients who desire Medicaid coverage must participate in the managed care program. Note, also, that some services do not require a PCP referral.

PCPs are paid a per-recipient management fee per month, in addition to reimbursement for the medical service they provide. The management fee is automatically paid to the PCPs at the end of each quarter based on the number of recipients on their case load as of the last day of the month. Physicians whose primary specialty area is family practice, general practice, internal medicine, or pediatrics and adolescent medicine must enroll as PCPs to participate in Medicaid. Enrollment as a PCP is optional for obstetricians and gynecologists.

PCPs may refer to specific providers by name as long as the PCP allows the patient to choose from two or more physicians of the same specialty. If the patient elects to go to a non-referred provider, then the patient generally will be responsible for the charges incurred. The referred-to provider must indicate the authorization by the PCP on the Medicaid claim by noting the PCP's provider number. Further, the PCP must file documentation of the referral in the patient's medical record - either the referral notice, or a notation of verbal referral.

Arkansas Medicaid Physician Provider Manual §§ I-170.000 and following, -171.230, -171.400 and following (Rev. 07/2005, 04/2006).

Discrimination

PCPs may not reject an enrollee because of the person's age, race, sex, national origin, or type of condition. However, rejecting a person because of age or sex is not discrimination if the physician's practice is naturally limited in that manner, for instance a gynecologist who sees only women or a pediatrician specializing in adolescent medicine who treats only patients age 12 to 18.

Arkansas Medicaid Physician Provider Manual §§ I-171.220 (Rev. 07/2005).

Nurse Practitioners and Physician Assistants

Nurse practitioners and physician assistants may not be PCPs in the Medicaid program, but they may provide care to a PCP's patients, under certain restrictions outlined in the Provider Manual.

Arkansas Medicaid Physician Provider Manual §§ I-171.100 (Rev. 09/2009), -171.630 (Rev. 07/2005).

Prior Authorization

Medicaid requires prior authorizations before it will pay for certain medical and surgical procedures. See Arkansas Medicaid Physician Provider Manual § II-260.000 (Rev. 11/2009). To obtain prior authorization for these procedures, the physician or the physician's nurse must call the Arkansas Foundation for Medical Care (AFMC) at (877) 650-2362 between 8:30 a.m. and 5:00 p.m., Monday through Friday.

Arkansas Medicaid Physician Provider Manual § II-261.100 (Rev. 04/2007).

Illegal Medicaid Participation

"Medicaid fraud" includes "illegal Medicaid participation." A person commits illegal Medicaid participation if he has been found guilty of or has pled guilty or nolo contendere to Medicaid fraud, theft of public benefits, or abuse of adults, and that person participates, directly or indirectly, in the Arkansas Medicaid program. Similarly, it is illegal Medicaid participation for a Medicaid provider or the provider's fiscal agent to employ or engage as an independent contractor or as a consultant, or otherwise permit the participation in the provider's business, of any person who has been found guilty or pled guilty or nolo contendere to the crimes listed above.

Ark. Code Ann. § 5-55-101 and following; § 20-77-901 and following.

ARKids First Program

The Medicaid ARKids First Program provides health care services to impoverished children whose families' income exceeds the regular Medicaid threshold. Specifically, ARKids First covers children age 18 years or younger who are members of a family with a gross income not exceeding 200% of the federal poverty limit and who are not otherwise eligible for Medicaid or other health care coverage. To be eligible for ARKids First Program reimbursement, physicians must be enrolled as Medicaid providers. The 2009 amendments to the Program changed the family income requirement to not exceeding 250% of the federal poverty guidelines and permitted coverage of ARKids-covered persons up through the age of 24 if they were full-time students enrolled in a college, university or technical institute in Arkansas, met the income requirements and were without other health care coverage. However, as of the time of

publishing the *2009 Legal Guide,* the required federal government approval for these provisions had not been obtained.

Ark. Code Ann. § 20-77-1104, *as amended by Act 435 of 2009.*

Independent Laboratories, CRNAs, Radiation Therapy Centers

The Medicaid Physician Provider Manual contains certain enrollment and other requirements that pertain only to independent laboratories, certified registered nurse anesthetists, and radiation therapy centers.

Arkansas Medicaid Physician Provider Manual § II.

Medicaid Fairness Act (Provider Due Process)

In 2005, the General Assembly passed the Medicaid Fairness Act, which sets out requirements "to ensure that the [Department of Human Services ("DHS")] and its outside contractors treat providers with fairness and due process." In 2007, the Medicaid Fairness Act was amended to clarify some of its original provisions. The law protects all Medicaid providers, including physicians. The primary features are as follows:

Technical Deficiencies

DHS may not recoup from providers for "technical deficiencies" if the provider can substantiate through other documentation that the services or goods were provided and the deficiency did not affect direct patient care. "Technical deficiencies" do not include lack of medical necessity, failure to meet the local standard of care, failure to obtain prior authorization when required; or fraud and abuse.

Provider Appeals

Providers have the right to an administrative hearing on any decision that adversely affects the provider or beneficiary (unless the provider has not furnished any service for which payment was denied). The provider's right to appeal cannot be conditioned on the beneficiary participating, nor denied for "technical or procedural" reasons by DHS. Providers have the right to appeal an unfavorable administrative decision to circuit court.

Explanations for Adverse Decisions

Each denial or other deficiency that DHS issues against a Medicaid provider must state in writing: (1) the exact nature of the adverse decision; (2) the statutory provision or specific rule alleged to have been violated; and (3) the specific facts and grounds constituting the elements of the violation.

Rebilling at an Alternate Level Instead of Complete Denial

When DHS denies a provider's claim, it must specify in a written notice what level of service it believes would have been appropriate to bill. The provider may then rebill at the alternate level. A decision to rebill does not waive the provider's right to appeal the decision.

Prior Authorization - Retrospective Reviews

DHS may not retrospectively recoup or deny a claim when it previously authorized the care, unless: (1) the previous authorization was based on conditions that later changed, rendering the care medically unnecessary, or (2) unless the provider gave false or incomplete information and

DHS would not have issued authorization if it had known the true information.

Medical Necessity

There is a presumption in favor of the medical judgment of the attending physician in determining medical necessity of treatment.

Promulgation Before Enforcement

Medicaid may not use policies, guidelines, manuals, or similar criteria as enforcement tools unless they have been promulgated under the Administrative Procedure Act. This does not affect a physician's obligation to follow the professional standard of care when treating patients.

Records

Providers are required to supply records free of charge to DHS only once; if the same records are requested again, then DHS must pay a copy charge.

Notices

When DHS sends notices with deadlines to providers, the deadline shall not begin to run before the next business day following the date of the postmark on the envelope, the fax transmission confirmation sheet, or the electronic confirmation record, unless otherwise required by federal law.

Ark. Code Ann. § 20-77-1701 and following*, as amended by Act 596 of 2007.*

MEDICAL CORPORATIONS — NAMES

Only persons who are licensed to practice medicine may form a medical corporation, *i.e.*, a corporation "for the study, diagnosis, and treatment of human ailments and injuries, whether physical or mental, and to promote medical, surgical, and scientific research and knowledge." Medical corporations must obtain a certificate of registration from the Arkansas State Medical Board. The name chosen for a medical corporation may include the names of shareholders or a deceased shareholder for up to one year after death. The name of any shareholder included in the corporate name must be that of a person employed by the corporation who is licensed to practice medicine.

Ark. Code Ann. §§ 4-29-301 to 307, 309.

MEDICAL ERRORS, VOLUNTARY REPORTING

The Patient Safety and Quality Improvement Act is designed to encourage *voluntary* reporting by physicians and other providers of medical errors. The information is reported to entities called Patient Safety Organizations (PSOs). The PSOs are to analyze the data to develop ways to improve patient safety and reduce medical errors. Federal regulations, effective in 2009, create the framework for implementation of the law, define terms used in the law, and address issues on confidentiality and privilege. *42 e-CFR § 3.10 and following*.

The statute covers "Patient Safety Work Product" (PSWP) that is either reported by a provider to a PSO or developed by a PSO itself. Such information is legally privileged and confidential, with certain exceptions. PSWP may be disclosed for use in a criminal proceeding, if a court determines the information is relevant and not available from any other source. Also, PSWP can be disclosed if an individual has sued for alleged retaliation based on reporting information to a PSO. The law does not shield patient medical records, billing and discharge information, or similar original information.

An accrediting body cannot take action against a provider's good faith participation in reporting PSWP and cannot require a provider to reveal communications with a PSO. The act is a floor, which means stronger state protections are not preempted. The act does not override HIPAA confidentiality protections; PSOs are to be treated as "business associates" of providers under HIPAA.

42 U.S.C. § 299b-21 to 299b-26.

MEDICAL RECORDS

Physician's Signature and Documentation in Hospital Medical Records

The Department of Health has promulgated many regulations for documenting patient care in hospital medical records. Listed below are several provisions, but a complete set of regulations may be obtained from the Division via its website, www.heathyarkansas.com.

The regulations require that physicians sign the admitting order or the initial progress note using, at a minimum, their first initial, last name, and title. Each entry into the medical record must be authenticated by the person who is the source of the information. Physicians may use electronic signatures created by code, number, initials or some other method developed by the hospital, so long as the way the signature is generated is by a confidential method or code known only to the physician.

Alternatively, the regulations permit a physician to use a rubber stamp bearing the physician's full legal name and professional title. However, the physician must take the following precautions: the physician must certify in a signed writing, kept on file by the hospital administrator, that he will be the only person using the stamp on his hospital records, and that he will keep the rubber stamp in his possession at all times. The physician must review the information before marking the signature to the record.

Hospitals must adopt a policy on dictation that permits authentication by electronic or computer generated signature. Each physician must be assigned a unique identifier which is generated through a confidential code. The physician must certify in writing that he is the only person authorized to use the signature code. The system must permit the physician an opportunity to verify that the document is accurate and the signature has been properly recorded. Transcribed reports dictated by other than the attending physician must be signed by the credentialed individual dictating the report and the attending physician. Dictation of reports by other than the attending physician is limited to history, physical, discharge summary and progress notes.

Physician's orders must be authenticated with a legible and dated signature in a timely manner as defined by the Medical Staff By-Laws. Telephone/verbal orders shall be recorded by appropriate personnel and co-signed by the originator within 96 hours.

Progress notes must be recorded, dated, and signed by the physician. The patient's medical condition determines the frequency of the physician's notes. Progress notes may be dictated, provided that they are dictated by the attending physician, transcribed, and placed in the patient's medical record within 48 hours of dictation.

A discharge summary must recapitulate the significant findings and events of the patient's hospitalization and the patient's condition on discharge, and must include the final diagnosis, all documented by the attending physician within 30 days of discharge.

In the event of a physician's death or permanent incapacitation, incomplete medical records for a patient shall be reviewed in a manner approved by the Medical Staff. Approval to file incomplete medical records must be obtained in a manner approved by the Medical Staff. A statement explaining the circumstances must be placed in each patient's record.

Errors

If the physician makes an error in his notes, the regulations are very specific as to how the error must be corrected. The regulations provide that the physician draw a single line through the incorrect information, label it as "Error", initial and date the entry. Under the regulations, erasures or obliterations of the original information in a medical record is never permitted.
Section 14, Ark. Dept. of Health Rules and Regulations for Hospitals and Related Institutions (2007).

Death Certificates

A death certificate may be signed by the attending physician, chief medical officer of the hospital, or a pathologist who does the autopsy as long as the person has access to the deceased's medical history, has viewed the coroner's report if required and death is due to natural causes. A registered nurse employed by an attending hospice may sign the death certificate for a patient who is terminally ill, whose death is anticipated, who is receiving services from a certified hospice program, and who dies in a hospice inpatient program or as a hospice patient in a nursing home.
Ark. Code Ann. § 20-18-601, as amended by Act 702 of 2007 and Act 1288 of 2009.

Retention of Medical Records

Hospital Records

All hospital medical records must be retained for ten years after the last discharge. These records may be retained either in the original form, microfilm or other acceptable methods. Complete records of minors must be retained for a period of two years following the age of majority according to the Department of Health regulations on hospitals, but a more conservative approach would be to retain those records for a period of seven years following the age of majority. The patient, physician parent or legal counsel may request a longer retention period.

After this period, the record may be destroyed, as long as the hospital permanently maintains the information required in the Master Patient Index. The Index at a minimum must contain: the patient's full name, address, birth date and medical record number. Regulations in 2005 required the Master Patient Index to contain the dates of all patient visits to the hospital. Prior to the issuance of the 1999 rules and regulations for hospitals, it was recommended that hospitals maintain a record of the following information for an additional 25 years: (1) dates of admission and discharge; (2) name of physician; (3) record of diagnosis and operations performed; (4) operative reports; (5) pathology reports; and discharge summaries for all admissions.

Section 14, A.11 and A.19, Ark. Dept. of Health Rules and Regulations for Hospitals and Related Institutions (2007).

Physician Records

All records required by the federal Health Insurance Portability and Accountability Act must be retained a minimum of six years.

As far as patient medical records, ethically the physician is bound to recognize that the interests of the patient are paramount. Medical records are important to the patient not only for medical care but also for employment, insurance, litigation, or other reasons. Therefore, a physician's ethical duty is to preserve medical records during the time there is a reasonable likelihood of their usefulness to the patient. The statute of limitations on medical malpractice actions is also a factor on how long to keep records, especially in the case of minors.

The Arkansas Medical Society recommends physicians keep records for at least ten years from the date of the last treatment, unless the patient is deceased, is incompetent or is a minor. In the case of a deceased patient, the AMS recommends keeping the patient's records for at least six years after the date of death. If the patient is incompetent, the AMS recommends keeping the records for as long as the patient is living or for six years following the patient's death. If an incompetent patient is adjudicated competent, then at a minimum, the patient's records should be kept for six years after the adjudication of competency, assuming there is no medical treatment provided after the adjudication. If a patient receives treatment after being adjudicated competent, then the regular ten-year recommendation applies. Each new treatment "restarts the clock" on the time for keeping records.) If a physician's last treatment of a patient occurred when the patient was a minor, the AMS recommends keeping the records for at least ten years after the minor reaches age nine. Keep in mind that the provision of new treatment "restarts the clock." For example, if a physician first saw a patient at age ten and then saw the patient only one more time when the patient was age thirteen, the AMS recommends that the patient's entire medical record be kept by the physician for ten years after the last visit, which in this example would be until the patient reached age 23.

Generally, a medical malpractice action must be commenced within two years after the alleged malpractice. However, in surgical cases in which a foreign object is left in the body, and it is not discovered and could not reasonably have been discovered within the two-year period, an action may be brought within one year from the date of the discovery or the date the foreign object reasonably should have been discovered. ***See Malpractice, Tolling of Statute of Limitations, at page 159.***

Different statute of limitations rules apply to minors. A minor who was nine years old or younger at the time of the alleged malpractice has until the later of his eleventh birthday or two years from the date of the alleged malpractice in which to bring a lawsuit. However, if no medical injury is known and could not reasonably have been discovered prior to the minor's eleventh birthday, then the minor has until two years after the medical injury is known or reasonably could have been discovered, or until the minor's **nineteenth** birthday, whichever is earlier, in which to commence a lawsuit.
Ark. Code Ann. § 16-114-203(c)(1-2).

When a physician dies, retires, or sells his medical practice, patient records may be forwarded to a new physician at the patient's request, forwarded to the patient, forwarded to a custodian physician with notice to the patient, or stored with notice to the patient. If the

forwarding physician's file contains records from other physicians, those records should be forwarded with the rest of the patient's file. Reasonable means should be considered as an alternative to outright destruction.

Confidentiality

Medical records are confidential, and in most cases may not be released without the patient's written authorization. Further, original medical records may not be removed from a hospital except by court subpoena. The federal law on privacy of personal medical information, the Health Insurance Portability and Accountability Act (HIPAA) has greatly impacted confidentiality concerns. ***See HIPAA at page 115.***

Because of overriding social considerations, there are some exceptions to the confidentiality rule. For example, physicians must divulge credible threats made by patients to inflict serious bodily harm to themselves or other persons because physicians are responsible for taking reasonable precautions to protect the intended victim. Physicians are also obligated to report to the appropriate authorities incidences of communicable diseases; gun shot and knife wounds; adult abuse, child abuse; sexual abuse, and sudden infant death. *AMA Code of Medical Ethics § 5.05* In addition, HIPAA allows use and disclosure of medical records without explicit authorization for purposes of treatment, payment and certain health care operations as well as in certain court hearings.

See Reporting, Mandatory Physician at page 216; HIPAA, TPO Umbrella at page 117.

Under state law, the Insurance Commissioner has the authority to share confidential and privileged information with other regulatory and legislative agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with law enforcement authorities, as long as the recipient agrees to maintain the confidentiality and privileged status of the information. State law permits the Commissioner to enter into agreements with such other agencies regarding the sharing and use of such information. No privilege or claim of confidentiality will be considered waived as a result of disclosure to the commissioner under this Act, and a privilege established under the law of any other jurisdiction that is substantially similar to the privilege established under this Act will be available and enforced in any proceeding in Arkansas. However, HIPAAmay pre-empt some of these state law provisions. Physicians should consult with legal counsel before making such disclosures without a patient authorization. ***See HIPAA at page 115.***
Ark. Code Ann. § 23-61-107(a)(5).

HIV/AIDS/Sexually Transmitted and Communicable Diseases

Laboratory notifications of communicable diseases are confidential and may be inspected only by public health personnel. Also, the identity of persons participating in the Department of Health AIDS testing program must be kept secret.
Ark. Code Ann. §§ 20-16-504; 20-15-901.

See Acquired Immune Deficiency Syndrome at page 24.

Sex Crimes and Release of Medical Records

Prosecuting attorneys may obtain a warrant to access relevant medical records of a person charged with having committed a sex crime that could have exposed the victim to a disease.

Relevant medical records are those that may reveal a health risk to the victim. To obtain the warrant, the prosecutor must set forth the facts giving rise to reasonable cause to believe that the suspected offender may present a danger to the victim's health. If such a warrant is issued and served on persons having custody of the suspect's relevant medical records, then the prosecutor must be permitted to have access to the records. If a medical care provider provides such access after being served with the kind of warrant described above, the medical care provider cannot be subject to any liability for granting the access.

If the prosecuting attorney determines, after reviewing the records, that the victim is subject to a health risk as a result of the offense, the prosecutor may convey that information to the victim, or to the victim's parents or legal guardians if the victim is a minor or is incompetent.

While HIPAA does permits disclosure of Personal Health Information (PHI) to law enforcement in certain circumstances, physicians may wish to consult legal counsel before making disclosures under this state law.

Ark. Code Ann. § 5-14-201 to 202.

Alcohol and Drug Abuse Information

A patient has the privilege to refuse to disclose in court and to prevent others from disclosing medical records or confidential communications made for the purpose of diagnosis or treatment of a physical, mental or emotional condition, including alcohol or drug addiction.

Ark. Code Ann. § 16-41-101; Arkansas Rule of Evidence 503.

Federal law restricts release of information concerning a patient's participation in a drug and alcohol treatment program that receives federal funds. However, the patient may authorize release of this information so long as the authorization contains the following information: (1) the name of the patient; (2) the name of the program or person permitted to make the disclosure; (3) the name or title of the person or organization to whom disclosure is to be made; (4) the purpose of the disclosure; (5) how much and what kind of information is to be disclosed; (6) the patient's or guardian's signature; (7) the date the authorization was signed; (8) a statement that the authorization may be revoked at any time; (9) a date, event or condition on which the authorization will expire if not revoked before, and (10) a statement restricting further disclosure without the patient's authorization. ***See also HIPAA at page 115.***

The patient's authorization is not required under three conditions: (1) when disclosure is made to medical personnel who need the information for treating a condition that poses an immediate threat to the health of any person and which requires immediate intervention; (2) for the purpose of scientific research, business audits, or program evaluation, but only if the patient's identity is not disclosed; or (3) if there is a court order and a subpoena.

42 U.S.C. §§ 290dd-3, 290ee-3; 42 Code of Federal Regulations § 2.1 and following.

Drug-Dependent Patients. Under Arkansas law, the Director of the State Health Department is permitted to collect and share records of drug-dependent persons for federal, state and local law enforcement purposes. However, a physician "is not required or compelled to furnish the name or identity of a patient or research subject to the director nor may he be compelled in any state or local civil, criminal, administrative, legislative or other proceedings to furnish the name or identity of an individual that the practitioner is obligated to keep confidential." *Ark. Code Ann. § 5-64-504(c).* This means that if a patient tells his physician that he is drug-dependent or is using illegal drugs, the physician cannot be compelled to divulge the patient's name to law enforcement or to the Arkansas State Health Department. However, the portion of this state law

that permits the collection of records of drug-dependent persons, may be pre-empted by the federal Health Insurance Portability and Accountability Act. Physicians should consult legal counsel before providing records under this state law. ***See HIPAA at page*** 115.

Mental Illness

As with general patient-physician privilege, Arkansas law protects communications relating to diagnosis or treatment of a mental condition. Also HIPAA contains additional restrictions on the release of notes from psychotherapy sessions.

Records procured by the State Hospital and its division for mental research are confidential and are generally inadmissible in evidence. Ark. Code Ann. § 20-46-104 permits individuals, hospitals and others to provide the information to the State Hospital. Because of HIPAA, physicians should consult legal counsel before making any unauthorized disclosures in reliance on this law.

Ark. Code Ann. §16-41-101; Ark. Code Ann. § 20-46-104; Arkansas Rule of Evidence 503.

Access to Referring or Transferring Physicians' Records

The welfare of the patient is of primary importance in the practice of medicine. As such, physicians must do everything reasonably and lawfully possible in serving the patient. Therefore, on request by another physician, the former physician should make available the patient's records. A patient authorization is not required under the federal Health Insurance Portability and Accountability Act if the transfer is for treatment purposes. ***See HIPAA, TPO Umbrella, at page 117.*** Furthermore, physicians should not refuse access to medical records because the patient has not paid his bill.

AMA Code of Medical Ethics, § 7.01; 45 Code of Federal Regulations §164.506.

See HIPAA at page *115.*

Access to One's Own Medical Record

Under the federal Health Insurance Portability and Accountability Act, patients have the right to inspect and copy their own medical records. The process under HIPAA allows providers to require a written request. The physician may charge a reasonable rate for copying medical records. ***See Access for Purposes of Litigation, below. See HIPAA at page 115.***

The practice must respond to a request to inspect and copy medical records within thirty days for information stored on site and within sixty days for information stored off site. The practice can request one thirty-day extension, if it provides the patient with a written notice of the reason for the delay. The practice must provide access in a "timely manner." A physician does have the right to deny access in limited circumstances, but in that event, the patient must be notified in writing in a "timely manner" and the notification must explain the basis for the denial. Denials can be made in a number of situations. You should consider consulting your attorney before denying an individual access to his or her medical record. Reasons for denials include that, based on the professional's judgment: (1) access would be likely to endanger the life or physical safety of the patient or another person, (2) the records reference another person and access might cause substantial harm to the other person, or (3) the professional has determined that access should be denied based on professional judgment. In these situations, the patient may submit a request for review by another licensed health care professional who did not participate in the original denial. The patient may also file a complaint with the Privacy Officer of the provider's practice or with the federal Department of Health and Human Services.

Unless a contract signed by the physician controls the issue of ownership, medical records are viewed as the property of the physician. Nevertheless, the information contained within the record is viewed as the property of the patient and cannot be released to most third parties without the written consent of the patient, subpoena, a court order, or by law. **However, see *HIPAA, TPO Umbrella at page* 117.** Some courts have pointed to the fiduciary qualities of the physician-patient relationship which places a duty on the physician "to reveal to the patient that which, in his best interest, he should know."

Access for Purposes of Litigation

In addition to the rights granted by HIPAA, Arkansas law allows patients or their attorneys who are contemplating a legal action the right to obtain the information in the patient's medical record upon the patient's written authorization and payment of photocopy charges. Photocopy charges are limited to $0.50 a page for the first twenty-five pages, and $0.25 for each additional page. A hospital or physician's office may charge a labor charge not exceeding $15.00 or an additional retrieval fee for stored records for each medical record request, and physicians may charge an additional fee for providing a narrative medical report, but the patient should be notified in advance of the charge. The actual cost of any required postage may also be charged.

Should the physician determine that releasing the medical record would be harmful to the patient, he must provide a written explanation to the patient, or the patient's attorney or guardian. In this case, the patient, his attorney or guardian may ask a second physician in the same type of practice to review the patient's record and determine whether the contents would be harmful to the patient if released. If the second physician finds that the material in the record would not be harmful to the patient, then the record must be released. On the other hand, if the second physician finds that the material would be harmful to the patient, then either the record must not be released, or the objectionable material must be obliterated from the record before release. The patient is responsible for the cost of this review.

If after making reasonable requests and the expiration of a reasonable time, the patient is forced to use the subpoena process to obtain copies of his medical record, the issuing court will grant the patient attorney's fees and court costs against the medical provider. ***See Malpractice, Tolling of the Statute of Limitations, at page 159.***

Ark. Code Ann. § 16-46-106, as amended by Act 662 of 2007.

Any person involved in a lawsuit who obtains a patient's medical records from a physician, hospital or other custodian of records by using a subpoena, court order or a consent form signed by the patient must provide written notice of the receipt of the records to the patient or patient's attorney if the patient is represented by an attorney. The notice must indicate the provider from whom the records were obtained.

Ark. Code Ann. § 16-46-401 and following.

***See HIPAA at page* 115.**

Access to Child's Medical Records by Divorced, Separated or Unmarried Parents

The parent with whom the minor child lives most of the time is often referred to as the "custodial parent." The other parent, if the parties are divorced or separated, may be called the "non-custodial parent." The divorce decree or separation agreement may state specifically: *Each parent has equal access to all medical records of the couple's minor children,* or words to that effect. The decree should suffice under the court order exception of HIPAA to permit disclosure. There is no state law that prohibits the non-custodial divorced or separated parent from having

access to his or her child's medical records.

If the parents have never married, and the father is a non-custodial parent who has a court order or birth certificate recognizing his paternity, then he is treated as if he were separated or divorced from the mother, for purposes of access to the child's medical records. If a non-custodial father does not have a court order or birth certificate recognizing him as the father, consult with legal counsel before providing any medical records to him. Unmarried mothers' names should appear on the child's birth certificate. Consult with legal counsel if there is any doubt as to whether the person seeking the minor's medical records is actually the child's parent.

Step-parents generally have no right to access a step-child's medical records unless they have a court order permitting them to do so or written authorization from the parent.

Subpoena of Medical Records

Liability

Under state law prior to the passage of the federal Health Insurance Portability and Accountability Act (HIPAA), the custodian of medical or health records was immune from all liability for providing access to, or copies of such records, pursuant to a subpoena issued by "any board, agency, commission, prosecuting attorney or grand jury." *Ark. Code Ann. § 20-9-310, as amended by Act 4 of 2006*. This law may be pre-empted by HIPAA, so physicians should consult with legal counsel before making any disclosures in reliance on this state law.

While the HIPAA Privacy Standards enable providers to respond to subpoenas in civil proceedings or for law enforcement purposes without authorization from a patient, the Standards contain confidentiality protections that must be followed.

Subpoenas for law enforcement purposes or accompanied by a court order.

If a subpoena seeks Protected Health Information (PHI) and is (1) issued by a grand jury or a judicial officer for law enforcement purposes or (2) is accompanied by an order of a court or administrative tribunal, a covered entity may disclose the PHI without further inquiry and without authorization by the patient. ***(See Health Insurance Portability and Accountability Act (HIPAA) at page 115 for definitions of PHI and Covered Entity and explanation of The Privacy Standards.)*** If an administrative subpoena is issued for law enforcement purposes, the covered entity may disclose PHI without an authorization if: (1) the information is necessary and material to a legitimate law enforcement inquiry; (2) the request is limited in scope to the amount of information necessary under the circumstances; and (3) de-identified information could not reasonably be used.

Non-law enforcement subpoenas or subpoenas without court order.

If the subpoena is not accompanied by a judicial order and the subpoena does not relate to a law enforcement inquiry, the Privacy Standards allow disclosure of PHI, without a patient's authorization, only if the covered entity either: (1) receives satisfactory assurances that the subpoenaing party has made reasonable efforts to notify the person whose PHI is the subject of the subpoena; (2) receives satisfactory assurances that the party subpoenaing the records has gone to court to obtain a protective order to safeguard the privacy of the PHI; or (3) the covered entity itself takes reasonable steps itself to provide such notice or obtain a protective order.

Subpoena by a Coroner

Under state law, a coroner may subpoena medical records and testimony relevant to the

determination of a person's cause of death. Under HIPAA, the executor or administrator of the deceased estate can invoke the Privacy Rights of the deceased. Physicians should consult with legal counsel to make sure HIPAA provisions are followed prior to releasing PHI

Physicians should note that a Power of Attorney for a patient expires upon the patient's death. Therefore a Power of Attorney may not be used to authorize release of PHI for a deceased person.

Ark. Code Ann. § 14-15-302, as amended by Act 194 of 2007, and Act 1288 of 2009.

Use of Records in Medical Research

Under Ark. Code Ann. § 20-9-304, data collected by the State Board of Health, Arkansas Medical Society, allied medical societies and in-hospital staff committees is treated confidentially when used in the course of medical studies aimed at reducing morbidity and mortality. The state law provides that organizations providing health care services may report data relating to the condition and treatment of patients for the purpose of reducing morbidity or mortality to the above listed bodies, or the any other national medical organization approved by the State Board of Health. There is no liability for damages in providing this information, or for releasing or publishing the findings and conclusions of the studies to advance medical research and medical education, or for publishing a summary of the studies. However, the identity of persons studied is confidential and must never be revealed. For purposes of litigation, this information is considered privileged, and may not be used as evidence in any legal proceeding.

Ark. Code Ann. § 20-9-304, which provided this protection, may be preempted by the more stringent federal Health Insurance Portability and Accountability Act (HIPAA). Legal counsel should be consulted before any information is disclosed or collected in reliance on this state statute**.** ***See Insurance, Utilization Review, at page 139; HIPAA at page 115; Tort Liability, Hospital Utilization Review Committees at page 239.***

Ark. Code Ann. § 20-9-304.

In 2005, a state law was passed that permits the state Department of Human Services, for purposes of research and aggregate statistical reporting, to provide data to the Arkansas Center for Health Improvement and the Agency for Healthcare Research and Quality for the Healthcare Cost and Utilization Project, or other researchers for research projects approved by the Department of Health. The department also must provide data to the Arkansas Hospital Association for its price transparency and consumer-driven health care project, making price and quality information about Arkansas hospitals available to the public. The Department is authorized to provide data for other researchers for research projects approved by the Board of Health. The law requires the data to be treated in a manner consistent with HIPAA and makes it unlawful for the Arkansas Center for Health Improvement to release any patient identifying information to any nongovernmental third party. Any identifiable data provided, collected or disseminated under this law shall not be subject to discovery in a lawsuit or available under the state Freedom of Information Act.

Ark. Code Ann. § 20-7-305, as amended by Act 616 of 2007.

MEDICAL WASTE DISPOSAL

The medical waste disposal regulations of the Health Department apply to all health care

related facilities that generate medical wastes. The regulations do not apply to medical wastes generated at a patient's home as a result of a home health visit, a physician's visit, or by the patient. However, the health care provider should instruct the patient in proper disposal methods. Facilities generating medical waste should obtain a copy of these detailed regulations from the State Health Department. What follows is an overview of the regulations.

Segregation of Medical Waste

Medical waste must be kept separate from other regular waste at the point of its generation in the producing facility. Medical waste must be stored in containers that are closable and constructed so as to contain the waste and prevent leakage of fluids during handling, storage, transport, or shipment. A non-sharps container (*e.g.*, a step can) must be kept closed at all times when not actively receiving waste.

Packaging and Labeling of Medical Waste

Medical waste, except for sharps capable of cutting or puncturing, shall be contained for reprocessing at the site of generation in collection containers impervious to moisture, which are leak resistant and have a sufficient strength to preclude ripping, tearing or bursting under normal conditions of usage. Full containers shall be securely closed to prevent leakage or loss of solid or liquid wastes.

Contaminated sharps shall be packaged for reprocessing at the site of generation in containers that are leak resistant on the bottom and sides, rigid, closable, and puncture resistant. Sharps that have been treated and are still capable of cutting or puncturing must also meet this packaging requirement unless they have been rendered unrecognizable and are no longer capable of cutting or puncturing.

Warning labels must be affixed to all bags and containers used for medical waste, or attached as close as possible to the container by string, wire, adhesive, or other method that prevents their loss or unintentional removal. Labels must be water resistant and legible, colored fluorescent orange or orange-red with lettering or symbols in a contrasting color, and include the universal biohazard legend. Red bags or red containers must be similarly labeled. Treated medical waste cannot be disposed of if it is in a red or orange-red bag or container. It must be further overpacked in a different color container and then labeled as explained below.

When medical waste leaves the facility where it was generated, the name and address of the generator must clearly be marked on the outside of the container. If the waste has been treated, then it must also be labeled with the words "Treated" and "Biohazardous Waste" or "Infectious Substance" or "Medical Waste" or the universal biohazard legend. Medical waste that has been treated by an approved method and determined by the Department as rendered unrecognizable, is not required to have special packaging or labeling when transported or disposed.

If medical waste requires labeling, packaging, or management under federal law, then the generator must comply with the labeling and other applicable requirements specified in those regulations.

Storage

Medical waste packaged in disposable containers as described above must be placed in disposable or reusable pails, cartons, drums, dumpsters, or portable bins. Disposable and reusable systems shall be kept clean and rigid, be designed to prevent leakage of fluids, remain impervious to moisture, and be of sufficient strength to prevent tearing or bursting under normal

conditions of use and handling and be kept sealed or closed to prevent leakage. The containers may be of any color and must be conspicuously labeled as described above.

Medical waste must be stored in a manner and location which affords protection from unauthorized entry, animals, adverse weather conditions such as rain, snow, ice, sleet, hail and wind, and which does not provide a breeding place or a food source for insects and rodents, and minimizes exposure to employees and the public. When waste is not being actively placed in storage, the area must be secured.

The location of the medical waste in storage shall be conspicuously marked with signs which shall include the universal biohazard legend.

Storage time within the generating facility must not exceed 30 days once the container has been filled and closed. Storage of medical waste for longer than 30 days must be approved by the state Department of Health. Filled containers of medical waste must be held at room temperature or below in a secure location with limited access.

Transport

Generators that transport their medical waste shall keep a log of all medical waste transported. The log shall include the quantity, the date of transport and the name of the receiving facility. Logs shall be maintained on file at the generator's facility for three years from the date of shipment.

For transport purposes, the generator shall transfer custody of untreated medical waste only to a transporter who has obtained a valid Commercial Regulated Medical Waste Transportation permit from the Department of Health. The generator of medical waste must maintain a log of all untreated medical waste transferred to a transporter. The log must include the quantity, the method used to determine the amount, the date the shipment was made, and the name and permit number of the transporter or treatment/disposal facility. The logs must be maintained on file at the generator's facility for three years from the date of shipment or transfer. Manifest/tracking paper may be substituted for the log.

The generator must obtain from the permitted transporter a signed receipt for each shipment of medical waste.

Ark. Dept. of Health Rules and Regulations Pertaining to The Management of Medical Waste From Generators and Health Care Related Facilities. (Effective date July 27, 2000.)

MEDICARE

Medicare is the federally funded program for the elderly (age 65 or older) and certain disabled persons. Various federal statutes and regulations govern the provision of Medicare services and are discussed throughout this Guide. Medicare Part A provides hospital insurance, while Medicare Part B provides physician and other non-institutional insurance. Medicare, like Medicaid, is governed by the Centers for Medicare and Medicaid Services (CMS) of the federal Health and Human Services Department. Local contractors oversee Medicare operations in each state. In Arkansas, the contractor is Pinnacle Business Solutions, Inc., a wholly owned subsidiary of Arkansas Blue Cross Blue Shield. Medicare "Part C" is an optional program available in some areas in which beneficiaries may enroll in an HMO or other managed care plan as opposed to traditional fee-for-service Medicare. In return, the beneficiary is entitled to receive an expanded

range of services. Formerly called Medicare+Choice, the program is now called Medicare Advantage. Part D is the prescription drug plan component of Medicare. The program is voluntary, and there are many different providers and plans available to Medicare beneficiaries. Medicare is an extremely complex program, and providers who participate must constantly keep abreast of Medicare guidance and changing requirements, or risk costly audits and recoupments and even charges of fraud and abuse. The *Provider News* bulletin, which keeps Medicare providers informed of CMS policies and guidelines on billing issues, is available at www.arkmedicare.com. CMS also maintains a detailed web site at www.cms.hhs.gov/home/medicare.asp and a voluminous online manual system.

***See also, Fraud and Abuse at page 101, Electronic Prescriptions under Medicare Part D at page 77, Electronic Prescriptions Under Medicare Part B at page 78*.**

MENTAL HEALTH

Purpose

It was the purpose of the legislature in enacting the following provisions to enable the Division of Behavioral Health Services of the Department of Human Services to assist in establishing and maintaining an effective system of services for persons with mental illnesses, and in so doing to reduce the occurrence, severity and duration of mental disabilities and to prevent these persons from harming themselves or others. (As of July 1, 2003, the Division of Mental Health Services changed its name to the Division of Behavioral Health Services, but the old name is still used in some statutes.)

The State's policy is to provide adequate and humane care to those persons with severe mental illness while at the same time applying means that are least restrictive of the person's freedom of movement and ability to function normally in society.
Ark. Code Ann. § 20-47-201.

Voluntary Commitment

Any person believing himself to have a mental illness may apply to the administrator or his designee of the University of Arkansas for Medical Sciences Hospital, the federal Department of Veterans Affairs Hospitals, any private hospital with a fully trained psychiatrist on staff, or treatment facility that has been designated by the Department of Human Services to care for persons involuntarily admitted to the state mental health system (hereinafter "hospital"). If after examination, the hospital determines that the applicant is in need of mental health treatment, the applicant may be admitted for the duration of time necessary for recovery, provided the applicant agrees to remain in the hospital.

If during the period of recovery the patient requests to leave, the hospital may determine whether the patient meets the criteria for involuntary admission as defined below, and if so, proceed with involuntary commitment procedures. Within one hour of making a request to leave, the hospital must provide the patient with a copy of "patients' rights" as described below along with an acknowledgment confirming that the hospital has advised the patient of his rights. If the patient refuses to sign the acknowledgment, then this fact must be noted in the patient's medical record and attested to by two witnesses on a separate document.

Should a patient leave the hospital without giving notice, the hospital may then issue a pick-

up order if the patient meets the criteria for involuntary commitment. Either the sheriff or a local law enforcement officer is responsible for transporting the patient back to the hospital.
Ark. Code Ann. § 20-47-204.

Involuntary Commitment

Petition

Any person having reason to believe that another person meets the criteria for involuntary admission to a mental facility may file a petition with the clerk of the circuit court of the county where the person alleged to have the mental condition resides or is detained.

The petition must contain the following information: (1) whether the person is believed to be of danger to himself or others; (2) the conduct, clinical signs, and symptoms on which the petition is based and on which the petitioner has personal knowledge; (3) the names and addresses of any witnesses having knowledge relevant to the allegations contained in the petition; and (4) a specific request for involuntary admission of the person to a hospital for treatment.
Ark. Code Ann. § 20-47-207, as amended by Act 1416 of 2007, and Act 680 of 2009.

Costs of Proceedings

When a person is found to be in need of involuntary admission to the state's mental health system, his estate is responsible for paying the cost of the proceedings. If the estate has insufficient funds to pay, then the county will pay the costs. If the person is discharged without admission, the person who prompted the proceedings will be responsible for paying the costs of the proceedings, unless the person who prompted the proceedings was an officer, such as a sheriff, coroner, constable, or justice of the county court, acting as part of his official duties. In that case, the county will pay the costs.
Ark. Code Ann. § 20-47-102; 105.

Criteria for Involuntary Commitment

A person is eligible for involuntary commitment if as a result of a mental illness, the person poses a "clear and present danger" to self or others. Clear and present danger means that (1) the person has either inflicted serious bodily injury on himself or herself or has attempted suicide or serious self-injury and there is a reasonable possibility that this behavior will be repeated; (2) the person has threatened to inflict serious bodily injury on himself or herself and there is a reasonable probability that such conduct will occur; (3) the person has demonstrated behavior that shows he or she so lacks the capacity to care for his or her own welfare that there is a reasonable probability of death, serious bodily injury, or serious physical or mental debilitation; or (4) the person's understanding of the need for treatment is impaired to the point that he or she is unlikely to participate in voluntary treatment where the person needs mental health treatment on a continuing basis to prevent relapse or deterioration of his or her condition and the person's non-compliance with treatment was a factor in placement in a psychiatric hospital or prison at least two times or in acts, attempts, or threats of serious violent behavior within the last 48 months.

Clear and present danger to others may be shown by evidence that the person has inflicted, attempted to inflict, or threatened to inflict serious bodily harm on another person, and there is a reasonable probability this conduct will occur.
Ark. Code Ann. § 20-47-207, as amended by Act 1416 of 2007, and Act 680 of 2009.

Patient's Rights

When a person faces involuntary commitment, he must be given a written statement of patient's rights, in addition to the copy of the petition and order directing appearance for an initial evaluation or detention. The notification of rights must contain the following:

1. The patient has the right to effective assistance of counsel, including the right to a court-appointed attorney;
2. The patient and his attorney have a right to be present at all significant stages of the proceedings and at all hearings, except that the attorney may not be present during the examination of the patient by a physician or other member of the treatment staff pursuant to an evaluation;
3. The patient has the right to present evidence in his own behalf;
4. The patient has the right to cross-examine witnesses who testify against him;
5. The patient has a right to remain silent; and
6. The patient has a right to view and copy all petitions, reports, and documents contained in the court file.

Ark. Code Ann. § 20-47-211.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Under the federal HIPAA law, state laws may be pre-empted in connection with certain procedures for involuntary commitments and for treatment of those persons who are involuntarily committed. For example, state law requires or permits physicians or other health care practitioners to disclose Protected Health Information (PHI) without a court order. Under HIPAA, generally a court order is required before PHI can be disclosed by a practitioner in such situations. Practitioners involved in involuntary commitments or treatment of the involuntarily committed should consult legal counsel before following the procedures set out in these statutes. ***See HIPAA at page 115*.**

Initial Hearing

The hearing for involuntary commitment must be held within three working days of the filing of the original petition. If the person named in the petition fails to appear, then the court will either issue an order of detention or dismiss the petition. However, the person named in the petition is not required to appear at the hearing and may even be excused if the court finds that the person is unable to appear because of physical infirmity; that appearance would be detrimental to the person's mental health, well-being, or treatment; or that his conduct before the court is so disruptive that the proceedings cannot reasonably continue with him present. The petitioner, on the other hand, must be present.

If the court determines, based on clear and convincing evidence, that there is probable cause to believe that the person has a mental illness and that one of the criteria listed above for involuntary admission applies, then the person must be admitted for evaluation and given, after 45 days, another hearing. Upon filing an order of commitment with a circuit clerk, the clerk must submit a copy of the order of commitment to the Arkansas Crime Information Center.

Ark. Code Ann. §§ 20-47-209, 214, as amended by Act 463 of 2007.

Immediate Confinement

If it appears that a person meets the criteria for involuntary admission and that immediate

confinement is necessary to avoid harm to such person or others, an interested citizen may take the person to a hospital for confinement. If this means of transportation is not safe, then it is the responsibility of the law enforcement agency in that jurisdiction to transport the person.

Alternatively, if the petitioner believes the person alleged to have a mental disorder is of immediate danger to himself or others, the petitioner may append to the petition a request for immediate confinement. The petition must state with particularity the facts personally known to the petitioner that establish reasonable cause to believe the person or the lives of others are in imminent danger of death or serious bodily harm due to the mental state of the person sought to be committed.

The petitioner must then appear before the circuit judge in a hearing to determine whether the person meets the criteria for involuntary admission and whether an imminent danger exists. If the judge determines that immediate confinement is necessary, the judge will order the local law enforcement agency to transport the person to an appropriate facility. The judge will further order a subsequent hearing within 72 hours of the person's detention and confinement. The facility's treatment staff may, however, release the person before the 72-hour hearing if in their judgment, further mental health treatment is not needed and they notify the court of the release in writing.

Ark. Code Ann. § 20-47-210.

Initial Evaluation and Treatment

The receiving hospital may detain the person alleged to have a mental illness for the purposes of evaluation and treatment provided that certain conditions are met. First, the hospital must inform the person of his rights as a patient. The treatment staff must determine the person to be a danger to himself or others. A hearing must be held within three working days. Finally, patients admitted to the hospital must be evaluated personally by a physician within 24 hours of detention. If the treatment staff determines that the detained person does not require further mental health treatment, the staff may release the person on immediate notification to the court in writing.

Ark. Code Ann. § 20-47-213.

Forty-five Day Involuntary Admission Hearing

Within seven days of detention, a public hearing must be held where the participants are under oath and subject to the penalty of perjury. If the court finds by clear and convincing evidence that the detained person is a danger to himself or to others, the court will issue an order authorizing the hospital to detain the person for treatment for a maximum of 45 days. The detained person may request treatment under the least restrictive alternative appropriate setting. Upon filing an order of commitment with a circuit clerk, the clerk must submit a copy of the order of commitment to the Arkansas Crime Information Center.

Ark. Code Ann. § 20-47-214, as amended by Act 463 o f 2007.

Additional 180-Day Involuntary Commitment

If the treatment staff of the hospital determines that the patient needs an additional period of treatment and supervision without which the patient poses a danger to himself, herself, or others, the staff may file a petition for an additional 180-day confinement that has been verified by the psychiatrist of the hospital. The petition must set forth the facts and circumstances forming the basis for the request. A public hearing will then be held where the participants are under oath and

subject to the penalty of perjury. Additional petitions may continue to be filed. Upon filing an order of commitment with a circuit clerk, the clerk must submit a copy of the order of commitment to the Arkansas Crime Information Center.
Ark. Code Ann. § 20-47-215,as amended by Act 463 of 2007.

Treatment

Arkansas law is very specific as to the types of treatment that may be delivered to patients. For example, the law provides that during the initial period of evaluation and treatment, psychotherapy and oral or intramuscular medication may be used if the effects of the medication on the behavior of the patient do not exceed 72 hours. Medication such as fluphenazine decanoate, or long-acting medication, or electroconvulsive therapy or psychosurgery must not be used during this period.

Other requirements include the following: psychosurgery must not be used during involuntary commitments to a "receiving facility;" electroconvulsive therapy may be used against a patient's wishes only if the circuit court orders the treatment after being presented with clear and convincing proof that this treatment is necessary; and short and long-acting medication may be used during the 45-day or 180-day involuntary commitment periods. In general, the staff must use the least intrusive means that will still achieve a successful result.

Furthermore, the treatment staff must submit to the court the patient's treatment plan, which will then be incorporated as part of the court's order for involuntary commitment. Should the treatment plan change at a later date, and the plan is more restrictive in setting or manner than the earlier plan, then the treatment staff must notify the court of the change.
Ark. Code Ann. § 20-47-218.

Costs of Treatment

Those who are legally bound to support a person in need of mental health services are responsible for paying the costs of such services to the extent that (a) the person in need of services cannot pay; and (b) those legally liable to pay are able to do so.
Ark. Code Ann. § 20-47-106.

When the county supplies the funds for the care or confinement of a person in need of mental health services, the county may recover those funds from anyone who is (a) bound by law to support the person in need of services; and (b) able to pay the amount.
Ark. Code Ann. § 20-47-107.

Fundamental Rights

A person receiving treatment for a mental illness retains all legal rights to which citizens are entitled, except as otherwise provided above. Most importantly, the person will not be deemed incompetent to manage his affairs, to contract, to hold any kind of driver's license, to marry or to divorce, to vote, to make a will or to exercise any other civil right solely by reason of that person's admission to the mental health system.

Persons receiving mental health services must not be discriminated against because of race, color, sex, religion, national origin, age, handicap, or degree of disability. And finally, they may not be neglected or abused.
Ark. Code Ann. § 20-47-220.

See also, federal and state Mental Health Parity Laws at page 138.

Evaluation and Treatment of Persons Who Commit Cruelty to Animals

In 2009, the law changed on how persons who commit cruelty to animals are evaluated and treated by the courts and expanded the definition of animal cruelty.

Under the new law, any person who pleads guilty or nolo contendere or is found guilty of cruelty to animals shall be fined, imprisoned or ordered to perform community service, and ordered to complete a psychiatric or psychological evaluation and, if determined appropriate, psychiatric or psychological counseling for a length of time prescribed by the court. The court may order the individual to pay the cost of any psychiatric or psychological evaluation, counseling, or both.

A person commits the offense of cruelty to animals if he or she knowingly (1) subjects any animal to cruel mistreatment; (2) kills or injures any animal owner by another person without legal privilege or consent of the owner; (3) abandons an animal at a location without providing for the animal's continued care; (4) fails to supply an animal in his or her custody with adequate shelter that is consistent with the breed, species, and type of animal; (5) fails to provide an animal in his or her custody with a sufficient quantity of wholesome food and water; or (6) carries or causes to be carried in or upon any motorized vehicle or boat an animal in a cruel or inhumane manner.

Act 33 of 2009, codified at Ark. Code Ann. § 5-62-103.

MINORS

Blood donations

Any minor who has reached 17 years of age may act as a blood donor to any nonprofit blood bank or licensed hospital without consent of the minor's parent or guardian. A minor who is 16 years of age may act as a blood donor, if the minor obtains the written permission or authorization from the minor's parent or guardian.

Ark. Code Ann. §20-27-301, as amended by Act 152 of 2009.

See Malpractice, Informed Consent, Divorced and Separated Parents and Authority to Consent to Treatment at page 156, Mature Minor Doctrine at page 158, Medical Records, Access to Child's Medical Records by Divorced, Separated or Unmarried Parents at page 177.

NEWBORN TESTING

Hearing Screening, Tracking and Intervention Program

Every Arkansas hospital that delivers more than fifty newborns each year is required to provide or arrange for a hearing test on each newborn. Hospitals with fifty or fewer births per year which elect to provide bilateral physiological hearing screenings are subject to the provisions set forth by the Department of Health. These provisions include: (1) each hospital shall designate a person to be responsible for the newborn hearing screening program in that facility, and this person will act as the single point of contact between the facility and the Arkansas Department of Health Infant Hearing Program; (2) each hospital shall make a reasonable effort, prior to discharge, to rescreen newborns who do not pass the initial screening; (3) each hospital shall forward the test results on a screening report to the Department by the fifteenth (15^{th}) day of the month following the month in which the test was conducted and they must make available information on follow-up care; (4) each hospital shall disseminate written information provided by the Department to the parent prior to the discharge; (5) each hospital shall provide written results of the initial hearing screening or parent refusal to the child's primary care physician within 14 days of discharge; (6) if a newborn is transferred to another institution before screening is completed, the receiving institution must provide hearing screening services; (7) each hospital shall calibrate the hearing screening equipment on at least an annual basis or as recommended by manufacturer guidelines; and (8) each hospital shall report to the Department on an annual basis on July 1^{st} and to amend any information within 30 days of a change.

No test is to be performed if the parent of a newborn/infant dissents on the ground that the test conflicts with personal religious belief or practice.

All providers or physicians completing follow-up screening or care for a hearing impairment in a newborn also are required to forward test results on a screening report to the Department of Health by the fifteenth of the month following the month in which the care was given.

Arkansas Department of Health Rules and Regulations Pertaining to the Universal Newborn/Infant Hearing Screening, Tracking, and Intervention Program (Rev. 2000).

Medicaid reimburses the hospital for the bilateral physiological hearing screening at a rate equal to the amount paid outpatient providers for the same service, in addition to the current rate of per diem paid to the hospital.

Ark. Code Ann. § 20-15-1502 to 1505.

Metabolic Testing

Under state law and applicable regulations, all newborn infants must be tested for phenylketonuria, hypothyroidism, galactosemia, sickle-cell disease, cystic fibrosis, biotinidase deficiency, congenital adrenal hyperplasia, amino acid disorders, fatty acid oxidation disorders, and organic acid disorders. . Follow-up treatments in affected infants must begin no later than ten (10) days after the newborn is diagnosed as positive. No test shall be performed if the parents or legal guardian of a newborn infant object to the testing on medical, religious, or philosophical grounds. Duties of Physicians.

In 2007, the Department of Health issued Rules and Regulations Pertaining to Testing of Newborns, which impose certain requirements on physicians and on hospitals. In all cases where an infant is born in a medical facility, it is the responsibility of the governing body and medical

staff of the facility to adopt and enforce policies and procedures which ensure that blood tests for these diseases are conducted. If an untested infant under six months old is admitted to a licensed medical facility, and the facility or the attending physician learns that the infant is untested, the tests must be performed. If the infant is discharged without completed testing, it is the responsibility of both the discharging facility and the attending physician to arrange for testing. If their efforts to arrange for testing fail, they both must notify the Department of Health. Physicians who assume care of infants under six months of age who come to their attention as being untested or inadequately tested are responsible for assuring collection and submission of usable blood samples for the infants.

Ark. Code Ann. § 20-15-302,; Ark. Code Ann. § 20-15- 304; Arkansas Department of Health Rules and Regulations Pertaining to Testing of Newborn Infants (Rev. 2007).

NURSING

Licensing

Arkansas law requires licensing of those persons practicing nursing for compensation, including registered nurses, advanced practice nurses, registered nurse practitioners, licensed practical nurses, and psychiatric technician nurses. Licenses are issued by the Arkansas State Board of Nursing.

Criminal Background Checks

Each first-time applicant for any type of nursing license shall apply to the Identification Bureau of the Arkansas State Police for a state and national criminal background check. The background check will be conducted by the Federal Bureau of Investigation. If a person has been found guilty, or has pleaded guilty or nolo contendere, to crimes listed in *Ark. Code Ann. § 17-87-312*, the person will not be eligible to receive or hold a nursing license, unless the board grants a waiver. For certain serious crimes, even if they were expunged, a person will be permanently disqualified from holding a nursing license.

The board may issue a six-month nonrenewable temporary permit for licensure to a first-time applicant pending the results of the criminal background check.
Ark. Code Ann. § 17-87-312.

Types of Licensed Nurses

There are several types of licensed nurses:

"Registered nurses" ("professional nurses") are nurses authorized to perform the following acts: the observation, care, and counsel of the sick; the maintenance of health or prevention of illness in others; the supervision and teaching of other personnel; the delegation of certain nursing practices to other persons as authorized by the regulations established by the Arkansas State Nursing Board; and the administration of medications and treatments as prescribed by an advanced practice nurse holding a certificate of prescriptive authority, a license physician, or licensed dentist, "where such acts require substantial specialized judgment and skill based on knowledge and application of the principles of biological, physical and social sciences."

"Advanced practice nurses" are registered nurses who have gained additional knowledge and skills through an organized program of nursing education that certifies nurses for advanced

practice roles such as advanced nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists.

"Advanced nurse practitioners" are registered nurses who have national certification of advanced knowledge and practice skills in the delivery of nursing services. Certified registered nurse anesthetists administer anesthetics under the supervision of, but not necessarily in the presence of, a licensed physician, licensed dentist, or other person lawfully entitled to order anesthesia. A certified registered nurse anesthetist may order nurses to administer drugs preoperatively and postoperatively in connection with an anesthetic or other operative procedure. Nurse midwives manage women's health care, with special attention to pregnancy, childbirth, the postpartum period, care of the newborn, family planning, and gynecological needs. Clinical nurse specialists are registered nurses who through graduate study have national certification of advanced knowledge and practice skills in a specialized area of nursing.

"Registered nurse practitioners" work in collaboration with and under the direction of a licensed physician or under the direction of protocols developed with a licensed physician. They may engage in other activities recognized by the nursing profession and authorized by the State Board of Nursing.

"Practical nurses" work under the direction of a registered nurse, an advanced practice nurse, a licensed physician, or a licensed dentist. They perform services that do not require the substantial specialized skill, judgment, and knowledge required in professional nursing.

"Psychiatric technician nurses" care for the physically and mentally ill, retarded, injured, or infirm. They work under the direction of a registered nurse, an advanced practice nurse, a licensed physician, or a licensed dentist when such activities do not require the specialized skill, judgment, and knowledge required in professional nursing.

Interstate Licensure Compact

Any registered nurse or licensed practical/vocational nurse who is licensed in a state that has adopted the Interstate Nurse Licensure Compact will be recognized as authorized to practice in Arkansas. Also, registered nurses and practical/vocational nurses licensed in Arkansas will be allowed to practice in any state that has adopted the Compact. Physicians or nurses who would like a list of states that have adopted this Compact may call the Arkansas State Board of Nursing at (501) 686-2700.

Ark. Code Ann. §§ 17-87-601 to 604.

When Licenses are Unnecessary

Nursing care may be given in the following situations without a license: nursing care in an emergency; nursing care that is incidental to a nursing education program approved by the State Board of Nursing; nursing care provided by a legally qualified nurse of another state who is employed by the United States government and is acting in the scope of his or her employment; nursing care provided by an out-of-state legally qualified licensed nurse who is engaged in patient transport so long as the care does not exceed 48 hours in this state; nursing care of the sick by an adherent following religious tenets of the church; the administration of anesthetics under the supervision of a licensed physician or dentist by a graduate nurse anesthetist awaiting certification results while holding a temporary permit, or by a registered nurse in the course of training in an accredited nurse anesthesia school; hospital-employed professional paramedics who administer medication for diagnostic procedures under the direction of a physician; or the prescription and administration of drugs or therapeutic devices in the presence of and under the

supervision of an advanced practice nurse holding a certificate of prescriptive authority, a licensed physician, licensed dentist, or by a registered nurse who is enrolled in an advanced pharmacology course and is acting in the scope of educational duties and who is under the direct supervision of a qualified instructor.

Additional exceptions exist for health maintenance activities by a designated care aide for a competent adult at the direction of the adult or for a minor child or incompetent adult at the direction of a caretaker. "Health maintenance activities" means activities that are beyond the activities of daily living, that enable the person to live in his or her private home, and that the attending physician, advanced practice nurse, or registered nurse have determined can safely be performed in the recipient's home.
Ark. Code Ann. § 17-87-103.

Penalties

A person who violates the licensing provisions is guilty of a criminal misdemeanor and subject to a fine of $25 to $500, with each subsequent offense punishable by a fine or by imprisonment of not more than 30 days, or both.

In addition, the Arkansas State Board of Nursing, after giving notice and a hearing, may impose civil penalties, not to exceed $1,000 for each violation. Each day of violation is a separate offense. The board may enforce this penalty in the Circuit Court of Pulaski County.
Ark. Code Ann. §§ 17-87-101 to 104.

Temporary Permits

Professional, Practical or Psychiatric Technician Nursing

The Arkansas State Board of Nursing issues temporary permits to practice nursing to qualified applicants who have applied and paid the required fee; who have completed a program in professional, practical, or psychiatric technician nursing approved by the appropriate state or national authorizing agency of this state or country, and by the appropriate authorizing agency of other states, territories or foreign countries; and who have applied for or are awaiting results of the first examination they are eligible to take after the permit is issued. The temporary permit expires on notification to the applicant of the examination results.

Temporary permits are issued to qualified applicants holding a current professional, practical, or psychiatric technician license from another state or territory who are awaiting endorsement in Arkansas. The temporary permit may last no longer than six months..

Advanced Practice Nursing

Applicants who have completed an educational program for advanced practice nursing are issued a temporary permit to practice; however the permit does not cover prescriptive authority. The permit expires on notification of examination results, and it is non-renewable. Advanced practice nurses currently holding a license from another state or territory are given a temporary permit while awaiting endorsement. This permit is valid for six months or less.
Ark. Code Ann. § 17-87-307.

License Renewal

Every two years, the Arkansas State Board of Nursing mails a notification for renewal to licensees at least 30 days prior to the expiration date of the license. Upon receipt of the completed application and the renewal fee, the board renews the license. A licensee who has

allowed his or her license to lapse may have it reinstated on payment of a renewal fee and penalty fee. A licensee may choose to have his or her license placed on inactive status. This is done by giving the board notice in writing. However, the provisions relating to denial, suspension, and revocation of a license are applicable to an inactive or lapsed license as well. An inactive license may be made active by following the rules established by the board.

As a condition of licensure renewal, an advanced practice nurse must submit proof of current national certification and successful completion of continuing education as required by the board.

Ark. Code Ann. § 17-87-308.

Disciplinary Actions

On proof that any of the following are present, the board may deny, suspend, revoke or limit a license or privilege to a person who:

1. is guilty of fraud or deceit in procuring or attempting to procure a license to practice nursing or is engaged in the practice of nursing without a valid license;
2. is guilty of a crime or gross immorality;
3. is unfit or incompetent by reason of negligence, habits, or other causes;
4. is habitually intemperate or is addicted to the use of habit-forming drugs;
5. is mentally incompetent;
6. is guilty of unprofessional conduct;
7. has had a license, privilege to practice, certificate, or registration revoked suspended, or placed on probation or under disciplinary order in any jurisdiction;
8. has voluntarily surrendered a license, privilege to practice, certification, or registration and has not been reinstated in any jurisdiction; or
9. has willfully or repeatedly violated any of the provisions of this chapter.

Ark. Code Ann. § 17-87-309, as amended by Act 207 of 2007.

The board shall refuse to issue or shall revoke the license of any person who is found guilty of or pleads guilty or nolo contendere to any offense listed in the code section on criminal background checks, unless the person requests and the board grants a waiver. However some more serious crimes, even if expunged, will result in permanent disqualification.

Anyone faced with a license suspension, revocation or other sanction is entitled to notice and a hearing. In addition, on request, the license or permit holder is entitled to know and have copies of any evidence that will be used against him.

Ark. Code Ann. § 17-87-312; Ark. Code Ann. § 25-15-208.

Medication Assistive Persons

"Medication Assistive Person" is a person who is certified by the Board of Nursing to administer certain nonprescription and legend drugs in designated facilities specified by the Board. Medication Assistive Persons also may perform related tasks while under the supervision of a licensed nurse. M.A.P.s may not administer controlled substances or administer parenteral, enteral or injectable medications; and, there are other restrictions on their duties set out in the statute.

Ark. Code Ann. §§ 17-87-203; 17-87-306; 17-87-701 to 711, as amended by Act 206 of 2007.

OCCUPATIONAL EXPOSURE TO BLOOD OR OTHER POTENTIALLY INFECTIOUS MATERIALS

Occupational Safety and Health Administration (OSHA) regulation 29 C.F.R. §1910.1030 imposes very specific safety requirements on employers whose employees handle blood or other materials that might be infected with disease-causing pathogens. The regulation requires that employers take certain precautions to prevent employee contact with disease-causing pathogens present in blood or other materials. The regulation covers these requirements in detail. For the most up-to-date electronic version of 29 C.F.R. §1910.1030, go to http://ecfr.gpoaccess.gov. Other information is available at OSHA's webpage, www.osha.gov/index.html, or call OSHA's Office of Health Compliance Assistance at (202) 693-2190.
29 Code of Federal Regulations § 1910.1030

OPTOMETRY

At the completion of an ophthalmic examination, an ophthalmologist, a physician practicing as an ophthalmologist, or an optometrist must provide the patient with a written prescription for eyeglasses at the patient's request at no additional charge. Written and signed prescriptions for contact lenses must be released at the patient's request without additional charge.

No person, firm, corporation or other legal entity located outside the state of Arkansas may fill, ship, mail, or deliver through electronic mail, the Internet, alternative channels or other means, contact lenses, vision-correcting contact lenses that have been medicated with legend drugs approved by the FDA, or other prescriptions for contact lenses or prescriptions to a resident of Arkansas without first having (1) registered and paid all applicable fees required by the State Board of Optometry; (2) possession of a positively verified written, signed, and unexpired contact lens prescription; and (3) registered to do business with the Secretary of State and designated a registered agent.

Optometrists and ophthalmologists licensed to practice in Arkansas may sell, prescribe, or dispense vision-correcting contact lenses that have been medicated with legend drugs approved by the Food and Drug Administration. However, this does not authorize dispensing of contact lenses medicated with Schedule I and II drugs, of medicated contact lenses that are not vision-correcting, or of medicated contact lenses for any purpose other than the diagnosis or treatment of diseases and conditions of the eye, lids, and adnexa. Persons or legal entities from outside Arkansas may dispense medicated contact lenses on these same terms if they meet the other requirements for doing business in Arkansas.
Ark. Code Ann. § 17-90-108, 109, as amended by Act 449 of 2009.

ORGAN DONATION

Anatomical Gifts

Who May Make an Anatomical Gift

Arkansas law on anatomical gifts was substantially revised in 2007. Physicians with

questions about specific cases may wish to consult legal counsel.

While the donor is alive, the donor may make an anatomical gift if the donor is an adult, an emancipated minor or is at least sixteen years of age. Others who may make an anatomical gift on behalf of a live donor can include the parent of an unemancipated minor and the donor's guardian.

After a donor's death, those authorized to make an anatomical gift of the donor's body or body parts, listed in order of priority, include: (1) certain agents of the decedent; (2) the decedent's spouse; (3) adult children of the decedent; (4) parents of the decedent; (5) adult siblings of the decedent; (6) adult grandchildren of the decedent; (7) grandparents of the decedent; (8) an adult "who exhibited special care and concern" for the decedent; (9) persons acting as guardians of the decedent at the time of death; and (10) any other person having the authority to dispose of the decedent's body.

If there is more than one person in one of the above classes, an anatomical gift may be made by a member of the class unless there is an objection by another class member. A person may not make an anatomical gift if, at the time of decedent's death, a person in a higher priority class is reasonably available to make or object to the making of the gift.

Refusal to Donate. An individual's unrevoked and properly documented refusal to make an anatomical gift bars all other persons from making an anatomical gift of that individual's body or body parts, with one exception. If an unemancipated minor who signed a refusal dies, a parent of the minor who is reasonably available may revoke the minor's refusal. "Refusal" is narrowly defined as a record created within the meaning of the statute that expressly states an intent to bar other persons from making an anatomical gift of an individual's body or body part. A donor's *revocation* of a prior writing making an anatomical gift is not considered a "refusal."

Designated Donees and Purposes for Which Anatomical Gifts May be Made

All of the following persons or entities may receive an anatomical gift ("designated donees"): (1) hospitals, accredited medical or dental schools, colleges or universities, organ procurement organizations, or other "appropriate person" for the purpose of research or education; (2) an individual if the individual is the transplant recipient of the part; and (3) an eye bank or tissue bank The 2007 statute sets out detailed rules on how anatomical gifts are to be used and on what entity or person ultimately receives the gift in various circumstances.

How an Anatomical Gift May Be Made

Donor. The donor of the anatomical gift may make a gift by driver's license or state-issued identification card, by a will, by donor card or other record, or during a terminal illness or injury, by any form of communication addressed to at least two adults with at least one being a disinterested witness. The 2007 law contains further provisions on documenting the donor's consent in different situations.

Others authorized to make. A person authorized to make an anatomical gift after the donor's death may make the gift by a document signed by the person making the gift or by that person's oral communication that is electronically recorded or is contemporaneously reduced to record and signed by the individual who received the oral communication

How an Anatomical Gift May Be Changed or Revoked

The 2007 revisions provide for more detailed procedures than in prior law on how gifts may be amended or revoked. Donor. If the anatomical gift was not made by will, then the donor may

change or revoke the gift by a record signed by the donor, or signed by other person authorized to make a gift before the donor's death, or signed by another person acting on the donor's direction if the donor is physically unable to sign; or by a later executed document of gift that changes or revokes a previous anatomical gift either expressly or through inconsistency. A donor or other person authorized to make a gift before the donor's death may also revoke an anatomical gift by destruction or cancellation of the document or portion of the document with the intent to revoke the gift. Any form of communication by the donor during a terminal illness or injury addressed to at least two adults, at least one being a disinterested witness will revoke or change an anatomical gift not made by will.

Gifts made by will may be changed or revoked in the same manner as provided for change or revocation of a will, or by any of the methods identified in the preceding paragraph for non-will gifts.

Others authorized to revoke. An anatomical gift authorized by persons permitted to make the gift on behalf of the decedent may be revoked or changed by any class member of a higher priority who is reasonably available. If more than one member of the higher priority class is available, the gift may be amended only if a majority of the reasonably available members agree to changing the gift. If more than one member of the higher priority class is available, the gift may be revoked only if the majority of the reasonably available members agree to revoking the gift or they are equally divided as to whether to revoke the gift. A revocation is only effective if, before an incision has been made or before invasive procedures have begun to prepare the recipient, the procurement organization, transplant hospital, physician, or technician knows of the revocation.

Advance Directives

A provision of the 2007 law addresses the interplay between a person's "living will" and the consent to be an organ donor. A prospective donor may have a declaration or advance health-care directive containing the prospective donor's directions on when a life support system may be withheld or withdrawn. If so, measures necessary to ensure the medical suitability if an organ for transplantation or therapy may not be withheld or withdrawn from the prospective donor, unless the declaration or directive expressly provides to the contrary. Practitioners should consult legal counsel before taking any action in reliance on this provision.

Duties of Coroners and Medical Examiners

The 2007 changes to the law set out, in more detail than in the prior law, the duties of coroners, medical examiners, prosecuting attorneys and procurement organizations in situations where an anatomical gift might be available or was made from a decedent whose body is under the jurisdiction of the coroner or state medical examiner. The new law discusses when organ recovery may be allowed or denied in certain circumstances involving autopsy and investigation into manner of death.

Ark. Code Ann. § 20-17-1201 and following.

Unclaimed Bodies

If after 48 hours, no one has claimed a dead body, then the person having possession or control must surrender the body to the University of Arkansas for Medical Sciences (UAMS), Department of Anatomy if the Department so requests. However, if the Department has proof

that the decedent had expressed during his last illness a desire to be buried or otherwise interred, then the Department may not accept the body. UAMS is responsible for the costs of embalming and transportation.

Once UAMS receives the body, it must hold it for 90 days, during which time relatives, friends, fraternal societies of which the deceased was a member, or charitable or religious organizations may claim the body for burial at their expense. They must reimburse UAMS for at least a portion of the embalming and transportation costs. After 90 days, title to the unclaimed body vests irrevocably in UAMS.

Ark. Code Ann. § 20-17-704 through 707, as amended by Act 839 of 2007.

Disposal of Tissues and Fetal Tissue

After a physician has finished scientific or medical examination of a tissue, the physician may dispose of it by incineration, cremation, burial, or other sanitary method approved by the State Board of Health, unless the physician has received a written request that the tissue be delivered to the patient or his or her representative. Delivery must comport with the rules and regulations of the State Board of Health. External parts of a human body, after removal, must be held 48 hours before disposal unless the patient or the person authorizing medical treatment, consents in writing otherwise. This same rule applies to a dead fetus, except that the mother or the mother's spouse must consent to an earlier disposal. A dead fetus is defined as:

> . . . a product of human conception exclusive of its placenta or connective tissue, which has suffered death prior to its complete expulsion or extraction from the mother as established by the fact that . . . the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

Ark. Code Ann. § 20-17-801.

The disposal of aborted fetal tissue is treated similarly to the disposal of other fetal tissue. Research may not be conducted on aborted fetal tissue without the permission of the mother.

Ark. Code Ann. §§ 20-17-802.

Limitation of Liability

No Strict Liability

Physicians, hospitals, blood banks, and tissue banks involved in the donation or transfer of any blood, organ, or tissue are not liable for the results of the activity unless they exhibit negligence or willful misconduct. Donation and transfer includes donating, preparing, obtaining, transplanting, injecting, and transfusing any blood, organ, or tissue, or participating in such conduct.

Ark. Code Ann. § 20-9-802.

PROFESSIONAL PEER REVIEW PROCEDURES, REPORTING, AND CONFIDENTIALITY

Peer Review Procedures Under Federal Law

Through the Health Care Quality Improvement Act of 1986, Congress addressed "professional review actions" based on "the competence or professional conduct of an individual

physician (which conduct affects or could affect adversely the health or welfare of a patient or patients)." The act requires reporting of adverse actions by review bodies. Among the "review bodies" having a duty to report actions taken against a physician are state medical boards, state medical societies, and hospital peer review committees. Insurance companies also have a duty to report settlement and malpractice claim payments against physicians. Because of the potential harm to physicians from erroneous reporting, federal law imposes notice and hearing procedural safeguards on review bodies to assure the physician has an opportunity to explain his or her actions or dispute the review body's findings. The act grants immunity from liability for damages to members of review bodies who act in good faith in the performance of their duties.

Duty to Provide Notice and a Hearing.

A review body that has collected sufficient data giving rise to a good faith belief that a physician's performance merits action, must inform the physician of its proposed action and then give the physician an opportunity to be heard. The review body must tell the physician the nature of the proposed action, reasons for the action, provide a summary of the physician's rights at any hearing, and then give the physician the right to request a hearing within a specified period of time. If the physician chooses to have a hearing, the review body must tell the physician the time, place and date of the hearing, which shall be within 30 days of the date of notice. The review body must also provide the physician with a list of the witnesses that it expects to call on its behalf.

The review body may decide to hold the hearing before any one of the following: an arbitrator who is agreed to by both sides; a hearing officer who is appointed by the review body and who is not in direct economic competition with the physician; or a panel of persons who the review body appoints, and who are not in direct economic competition with the physician. The physician has specific rights regarding the hearing, including the right (1) to be represented by an attorney; (2) to have a record made of the hearing, and to have a copy of the record; (3) to call, examine and cross-examine witnesses; (4) to present any relevant evidence; and (5) to submit a written statement at the close of the hearing. Following the completion of the hearing, the physician has the right to receive the written recommendation and the basis of that recommendation by the arbitrator, officer or panel, and to receive a written copy of the review body's decision along with the basis for that decision.

Immunity.

To receive the act's immunity from liability, members of the review body must take their actions (1) in the reasonable belief that the action was in furtherance of quality health care; (2) after a reasonable effort to obtain the facts of the matter; (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances; and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after the notice and hearing procedures are fulfilled. While a non-prevailing physician still may choose to sue, if the court finds that the suit is frivolous, unreasonable, or brought in bad faith, the physician will be responsible for the other party's costs and attorney fees.

Notice and a hearing need not be given when the review body takes no adverse action, or when it suspends or restricts the physician's clinical privileges for no longer than 14 days while it conducts an investigation.

42 U.S.C. §§ 11101 to 11152.

Federal Reporting Requirements: The National Practitioner Data Bank

Under the provisions of the Health Care Quality Improvement Act, state entities such as the Arkansas State Medical Board, the Arkansas Medical Society, hospitals and insurers ("reporting entities") are required to report to the Data Bank any time an adverse action has been taken against a physician. An adverse action is an action or recommendation by a health care entity based on the "professional competence or professional conduct of a . . . physician . . . which affects or could affect adversely the health or welfare of a patient . . .; and [w]hich adversely affects or may adversely affect the clinical privileges or membership in a professional society of a physician."

Reporting.

The reporting entities are required to disclose information that reflects badly on a physician's competence or professional conduct, usually within 30 days of the event. This means that the Data Bank has information related to disciplinary actions taken against a physician including the revocation or denial of a medical license; any limitation or denial of clinical privileges or membership in a health care entity; and payments made in settlement or in satisfaction of a claim or judgment against a physician, along with a description of the cause of injury on which the claim is based. Even though a settlement payment must be reported to the Data Bank, the Act specifically states that this payment is not to be taken as creating a presumption that medical malpractice has occurred.

Hospitals are required to request this information from the Data Bank any time a physician applies for privileges at the hospital and then again, every two years thereafter.

Disputes.

After receiving a report, the Data Bank will forward a copy of the report to the affected physician, who then has up to 60 days to dispute the accuracy of the report. The physician must state in writing the basis of the disagreement and request that the disputed information be reported to inquirers as being in a "disputed status." Simultaneously, the physician should attempt to resolve the dispute with the reporting entity. If the reporting entity revises the information, then the Data Bank will notify anyone to whom information has been sent that the information has changed.

Conversely, if the reporting entity does not revise the information, the Secretary of Health and Human Services will either decide that the information is correct, in which event the Data Bank will accept a brief statement by the physician and will include the Secretary's explanation of the basis for that decision; or if the Secretary concludes that the information was incorrect, he will send corrected information to previous inquirers.

45 Code of Federal Regulations §§ 60.1 to 60.14; 42 U.S.C. §§ 11101 to 11152.

Federal Confidentiality Provisions

Access. Access to Data Bank information is limited to: (1) hospitals in their credentialing process, (2) physicians who request information about themselves, (3) Boards of Medical Examiners or other state licensing boards, (4) health care entities that may be entering into affiliation agreements with a physician or to which the physician has applied for clinical privileges or appointment to the medical staff, (5) those persons who have filed a malpractice claim against a hospital and a specific physician, but only on showing that the hospital failed to

request information from the Data Bank as required when considering the physician's application for privileges, (6) a health care entity in connection with professional review activity, and (7) persons or entities who request information in a form that does not permit identification of the practitioner. The Act also provides a dispute mechanism for physicians to challenge the report. Other than in these circumstances, information in the Data Bank is to be held strictly confidential.
45 Code of Federal Regulations §§ 60.1 to 60.14; 42 U.S.C. §§ 11101 to 11152.

Peer Review Procedures Under Arkansas Law

The federal law described above does not preempt state laws such as Arkansas' to the extent the state law provides supplemental or greater protections than the federal law. Under Arkansas law, a peer review committee is one formed to evaluate and improve the quality of health care rendered by providers of health care services. Such a committee may be used by hospital medical staffs or medical societies. The committee accomplishes its goal by evaluating the medical necessity of individual services, ensuring that services complied with the appropriate standard of care, and assuring that the cost of services was reasonable for providers in that area.

Members of the committee enjoy a qualified immunity from monetary liability associated with acts undertaken in the scope of the functions of the committee. This means that members of the committee are not susceptible to any cause of action by the provider whose services they are reviewing if they acted with good faith and without "fraud or malice."

In addition, protection from discovery or introduction into evidence in a civil suit is extended to records of the committee's proceedings arising out of review and evaluation matters. The submission of peer review proceedings, minutes, records, reports, and communications to a hospital governing board does not operate as a waiver of privilege. Further, committee participants cannot be permitted or compelled to testify in a civil action as to the committee proceedings. However, the protection from discovery does not extend to documents that are otherwise available from originating sources, nor can a committee participant be prevented from testifying as to matters within his or her independent knowledge. Therefore, the only records protected are those created from the committee's proceedings, and a committee participant's testimony before the committee and opinions he or she formed as a result of the committee hearing.
Ark. Code Ann. §§ 20-9-501 to 503.

Reporting Physician Misconduct Under Arkansas Law

When to Report

Arkansas law requires that hospitals submit written reports detailing the revocation, limitation, or termination of hospital privileges for any cause, including resignation, to the Arkansas State Medical Board within 60 days after action is taken. Hospitals must also report disciplinary action taken against physicians concerning professional ethics, medical incompetence, moral turpitude, or drug or alcohol abuse. Reports need to include "pertinent information relating to the action."

Further Action Available

Hospitals may further suspend, restrict, or revoke privileges or membership of a physician regardless of any action taken by the Arkansas State Medical Board following the filing of a report.

Liability Immunity

Hospitals reporting any such disciplinary action cannot be held liable "for slander, libel, defamation of character, or otherwise because of the report."

Confidentiality

Any report and supporting information filed with the board maintains a shield of confidentiality negating disclosure except in specific instances. Disclosure of confidential information may only occur when needed for disciplinary hearings, trials, or appeals of board actions; when needed to inform licensing authorities or hospitals in any state "concerned with granting, limiting, or denying" privileges; or when ordered by a court.
Ark. Code Ann. § 17-95-104.

Peer Review Confidentiality Under Arkansas Law

Protected Information

Certain records are protected from discovery or introduction as evidence in legal proceedings. Generally, these records fall into the category of those prepared in the process of evaluation and review of the quality of medical or hospital care. Arkansas law protects the following types of documents: "proceedings, minutes, records, or reports of organized committees of hospital medical staffs or medical review committees of local medical societies." Testimony given in these proceedings is also protected.

Information That Is Not Protected

However, peer review records are not protected from state and federal regulatory agencies that are entitled to this information by law. In addition, the medical practitioner who is the subject of the committee's censure or discipline, may have access to this information in any subsequent legal action brought about by the committee's action.

Records kept in the care or treatment of any patient may be subject to discovery. The statute identifies as falling within this category, "original hospital medical records, incident reports, or other records kept with respect to the care of any patient."
Ark. Code Ann. § 16-46-105.

In litigation, the United States District Court for the Western District of Arkansas held that incident reports prepared as required by the hospital's policy and which did not contain "opinions of, or conclusions reached by any administrative staff or review committee" were subject to discovery in a legal action. *Cochran v. St. Paul Fire and Marine Insurance Co., 909 F. Supp. 641 (1996).*

See also, Credentialing Organizations at page 55; Fraud and Abuse, Health Care Integrity and Protection Data Bank at page 110.

PERMIT OF APPROVAL

During the 1960s and early 1970s, Certificate of Need (CON) programs emerged on the state level as a means of controlling the growth of health care facilities, services, and medical

technology. The federal government then required states to administer a CON program, through the National Health Planning and Resources Development Act of 1974, to control skyrocketing health care costs and to facilitate health planning. During the 1980s, the federal CON mandate was repealed; and as a result, many states either abolished or significantly reduced their CON programs. There has been much disagreement over the effectiveness of these programs.

In Arkansas, the Health Services Permit Commission is responsible for health care planning. The Commission evaluates the availability and adequacy of health facilities and services, but only as to long-term care facilities, hospices and home health agencies. The "permit of approval" has taken the place of the CON. The Health Services Permit Agency reviews applications for permits of approval in accordance with criteria established by the Commission.

Permits of approval are required for construction of, conversion into or expansion of long-term care facilities, hospices and home health services. The application for the permit of approval must include information that will allow the Agency to determine whether (1) the proposed project is needed or will be needed to meet the health care required for the population or geographic region; (2) the proposed project can be adequately staffed and operated when completed; (3) the proposed project is economically feasible; and (4) the project will "foster cost containment through improved efficiency and productivity."

The Agency will either issue a permit of approval or a written statement of denial setting forth the reasons for denial. Applicants may appeal a denial decision to the Commission within 30 days after the date of their receipt of the Agency decision.

Ark. Code Ann. §§ 20-8-103 to 107, as amended by Act 649 of 2009.

PHARMACY PRACTICE

Licensed pharmacists, who have met additional requirements of the State Board of Pharmacy, may administer medications to patients upon a physician's prescription and order. These medications are limited to immunizations, vaccines, allergy medications, vitamins, minerals, anti-hyperglycemics, and anti-nausea medications. A pharmacist may not administer medication to a person under the age of 18 years. A prescription order from a practitioner, for administration by a pharmacist, of an approved medication or immunization is known as an "Authority to Administer," which is valid for a period not to exceed one year, unless it is revoked by the practitioner prior to its expiration.

For a few specified diseases, qualified pharmacists also may provide "disease state management" for individual patients if the patients' physicians delegate that service to the pharmacist under a written protocol. The required contents of the protocol are set out in the Pharmacy Board regulations. "Disease state management" involves, but is not limited to, providing patient education and self-care techniques and out-patient drug therapy management. The diseases for which this service may be delegated are asthma, anticoagulation therapy, diabetes, and dyslipidemia.

For all patients, pharmacists are obligated to: (1) identify potential and actual drug-related problems, (2) resolve actual drug-related problems, (3) prevent potential drug-related problems, and (4) optimize patient therapy outcomes. For both new prescriptions and refills, a pharmacist must perform a drug use evaluation or drug utilization review that includes evaluation of dosage and route of administration; directions for use; drug interactions, allergies and contraindications;

duplication of therapy, and over- or under-utilization. If the pharmacist suspects a problem in one of these areas, the pharmacist must inform the physician and then document the process.

Pharmacists generally must provide "patient counseling" that explains, among other things, the name and general description of the medication dispensed, *i.e.*, antibiotic; route and time of administration, whether the drug has a significant side effect, and drug interactions. However, the applicable regulation states, "It is recognized that the ultimate decision to not provide patient counseling rests with the physician. If the physician in specific instances (blanket requests not accepted) requests that information NOT be provided to the patient and gives reason, the pharmacist should honor that request in almost all instances."

Ark. Code Ann. § 17-92-101, as amended by Act 355 of 2009; Ark. Code Ann. § 17-92-316. Ark. Pharmacy Bd. Reg. 9 (Rev. 7/2007).

Reciprocity

The pharmacy board has discretion to issue an Arkansas license to a pharmacist who is duly licensed in another state or U.S. territory, under certain conditions. This law also permits any member of the Arkansas State Board of Pharmacy, in the interim between board sessions, and upon evidence of the fitness of an applicant for reciprocity, to issue a temporary certificate authorizing the holder to practice pharmacy in this state. The temporary certificate expires on the date of the next meeting of the board after the granting of the certificate.

Ark. Code Ann. § 17-92-308.

Prescriptive Authority for Physician Assistants

Licensed physician assistants can have the authority to prescribe Schedule III through V controlled substances, all legend drugs, and to recommend all non-prescription medications and medical devices, if that authority is delegated to them by their supervising physician. Physician assistants who prescribe controlled substances must register with the federal Drug Enforcement Administration as part of the DEA's Mid-Level Practitioner Registry.

All prescriptions issued by a physician assistant must identify the supervising physician. Prescriptions for controlled substances also must contain the physician assistant's name and DEA number. Products dispensed to a patient based on a physician assistant generated prescription must state on the label the name of the physician assistant and "PA" behind the physician assistant's name.

Pharmacists are required to carry out the physician assistant's request or order in the same manner as they would for the supervising physician. A physician assistant's prescriptive authority can never exceed that of the supervising physician.

Ark. Code Ann. § 17-92-112.

See also, Physician Assistants at page 203.

PHYSICAL THERAPISTS

Physical therapists examine, evaluate, instruct, and treat patients with mechanical, physiological, developmental, and functional impairments.

The state law definition of the practice of physical therapy permits patients to receive

treatment from physical therapists without a physician referral. However, some third-party payors, such as Medicaid, still require a physician's referral before they will authorize payment.

Physical therapists provide therapeutic regimens that include exercise; functional training in self care; and manual techniques that include massage, mobilization, and traction, but exclude spinal manipulation. However, the therapeutic intervention of broncho-pulmonary hygiene, and debridement of wounds require a physician referral before treatment. Physical therapy does not include radiology or electrosurgery.

Physical therapists are licensed by the Arkansas State Board of Physical Therapy after having completed an accredited physical therapy program and having passed a national licensing examination.

Ark. Code Ann. § 17-93-102, as amended by Act 1471 of 2009.

PHYSICIAN ASSISTANTS (FORMERLY PHYSICIAN'S TRAINED ASSISTANTS)

A physician assistant is defined as a person who has graduated from an accredited physician assistant or surgeon assistant program and who has passed the certifying exam given by the National Commission on Certification of Physician Assistants. A physician assistant provides health care services under the supervision of a physician and works under a physician-drafted protocol approved by the Arkansas State Medical Board. Physician assistants may be delegated authority to write prescriptions. The State Medical Board has licensing, rule-making and disciplinary authority over physician's assistants.

Physician assistants, prior to 1999, were referred to in the law as "physician's trained assistants."

Licensure

Qualifications

A physician assistant must be licensed by the Arkansas State Medical Board. Applicants must: (1) submit an application on board-approved forms; (2) pay an initial licensure fee; (3) complete a physician assistant or surgeon assistant program accredited by the Committee on Allied Health Education and Accreditation or by its successor agency; (4) pass the Physician Assistant National Certifying Examination; (5) certify that he or she is mentally and physically able to safely practice as a physician's assistant; (6) be of good moral character; (7) not have a license, certification, or registration as a physician assistant that is under discipline, revocation, suspension, or probation for cause relating to the applicant's practice as a physician assistant, unless the board considers such condition and agrees to licensure anyway; (8) submit to the board any other information the board deems necessary; (9) be at least 21 years old; (10) obtain board approval, and (11) have at least a bachelor's degree in some field of study from an accredited college, unless the applicant; (i) has prior military service as a corpsman and meets other educational or certification requirements; (ii) was a physician assistant in a federal facility located in Arkansas on or after July 1, 1999 and meets other educational requirements; (iii) was licensed and in good standing on June 30, 1999 by the Arkansas State Medical Board; or (iv) was enrolled on or before July 1, 1999 in a physician assistant program which is recognized by the Commission on Accreditation of Allied Health Education Programs.

Graduate License/Temporary License

The board may grant a graduate license when an applicant has met all the requirements for licensure except that the applicant has not taken the national certifying examination or is awaiting the results. A graduate license is valid for one year from the date of issuance, or until the results of the exam are available, or until the board makes a final decision on the applicant's request for licensure, whichever comes first. The board may vote to extend a graduate license for only one, one-year period.

A temporary license may be granted to an applicant who has met all the qualifications for licensure but who is awaiting the next scheduled meeting of the board.

Exemptions from Licensure

No license is required for those persons who are (1) students enrolled in a properly accredited physician assistant or surgeon assistant program; (2) physician assistants employed by the federal government and performing duties incident to that employment; (3) technicians, assistants or employees who perform delegated tasks in a physician' office but who are not rendering services as a physician assistant or identifying themselves as such; (4) physician assistants in the service of the State Military Department, the Arkansas National Guard or both; (5) physician assistants temporarily traveling through the state while caring for a patient and under the supervision of his or her supervising physician.

Renewal

Every physician assistant licensed by the board is subject to renewal of his or her license upon notification by the board. Renewal requires: (1) paying fees as determined by the board; (2) completing the appropriate forms, and (3) meeting any other requirements set forth by the board.

Inactive License

A physician assistant may place his or her license on inactive status by notifying the board in writing on forms prescribed by the board. The physician assistant will not have to pay renewal fees and cannot practice as a physician's assistant as long as the license is inactive. To restore an inactive license, a physician assistant must pay the current renewal fee and meet all other requirements for renewal.

Penalties and Title Protection

Any person who is not licensed as a physician assistant, and who is not exempted otherwise, is guilty of a misdemeanor and subject to the penalties applicable to the unlicensed practice of medicine if he or she: (1) holds himself or herself out as a physician assistant; (2) uses any combination or abbreviation of the term "physician assistant" to indicate or imply that he or she is a physician assistant, or (3) acts as a physician assistant.

An unlicensed physician cannot use the title of "physician assistant" or practice as one unless he or she has fulfilled all the requirements to be a physician assistant.

Physician Assistant Practice

Notification of Intent to Practice

Prior to starting practice, a licensed physician assistant must submit on board approved forms, notification of intent to practice. The notification must include: (1) the name, business

address, e-mail address, and telephone number of the supervising physician; and (2) the name, business address, and telephone number of the physician assistant. The physician assistant must notify the board of any changes or additions in supervising physicians within ten (10) calendar days.

Identification

Physician assistants must keep their license available at their primary place of work and must wear a name tag identifying themselves as a physician assistant when doing their professional activities.

Scope of Authority

Physician assistants provide health care services with physician supervision. They may perform those duties and responsibilities, including the prescribing, ordering and administering drugs and medical devices, that are delegated by their supervising physicians.

Physician assistants are considered the agents of their supervising physicians in performance of all practice-related activities, including but not limited to, the ordering of diagnostic, therapeutic and other medical services. While a physician assistant may perform health care services in any setting authorized by the supervising physician and applicable facility policy, a physician assistant may not give eye exams with the purpose of prescribing glasses or contact lenses or the determination of the refractive power for surgical procedures; nor "adapt, fill, duplicate, modify, supply, or sell contact lenses or prescription eye glasses;" nor "prescribe, direct the use of, or use any optical device in connection with ocular exercises, vision training, or orthoptics."

Physicians may delegate prescriptive authority to physician assistants to include prescribing ordering and administering Schedule III through Schedule V controlled substances, all legend drugs and all non-schedule prescription medications and medical devices. All prescriptions and orders issued by a physician assistant shall also identify his or her supervising physician.

Physician assistants who prescribed controlled substances must register with the federal Drug Enforcement Administration as part of its Mid-Level Practitioner Registry.

At no time shall a physician assistant's level of practice exceed that of the supervising physician.

Patient care orders generated by a physician assistant must be construed as having the same medical, health and legal force and effect as if the orders were generated by the supervising physician as long as the supervising physician's name is identified in the patient care order.

Good Samaritan Provision

The same Good Samaritan provisions that cover Arkansas physicians also apply to physician's assistants.

See also, Emergency Medical Care, Good Samaritan Law at page 81.

Retired Physician Assistants Providing Medical Services to Less Fortunate Patients

Retired physician assistants may practice under the supervision of a licensed physician and are subject to the same provisions as a retired physician or surgeon. Retired physician assistants must continue to be licensed by the board.

See also, Service by Retired Physicians at page 231.

Medical Malpractice

Physician assistants are covered by the same laws on medical malpractice and legal liability as applies to their supervising physician.

See also, Malpractice at page 133.

Disciplinary Power of Board

The Arkansas State Medical Board has the power to discipline physician assistants. The board may refuse to grant a license; give public or private reprimands; revoke, suspend, limit or otherwise restrict a license; require a physician assistant to submit to care, counseling or treatment of a physician chosen by the board; place a physician assistant on probation, and restore or reissue licenses.

The board may discipline any physician assistant who: (1) fraudulently or deceptively obtains or attempts to obtain a license; (2) fraudulently or deceptively uses a license; (3) violates any provision of Arkansas law on physician's assistants or any applicable regulations adopted by the board; (4) is convicted of a felony; (5) is a habitual user of intoxicants or drugs to such an extent that he or she is unable to safely perform as a physician assistant ; (7) has committed an act of moral turpitude; or (8) represents himself or herself as a physician.

Supervising Physician Responsibilities

A "supervising physician" may be either a properly licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.). "Supervision" means overseeing the activities of, and accepting responsibility for, the medical services rendered by the physician assistant.

While the law states that supervision of the physician assistant shall be "continuous," the constant physical presence of the supervising physician is not required so long as the supervising physician and physician assistant are, or can be easily, in contact with each other by radio, telephone, electronic or other telecommunication device.

Requirements for Physicians

A physician desiring to supervise a physician assistant must: (1) be licensed in Arkansas; (2) notify the board of his or her intent to supervise a physician assistant, and (3) submit a statement to the board that he or she will supervise the physician assistant in accordance with any rules adopted by the board.

It is the obligation of each team of physicians and physician assistants to ensure that: (1) the physician assistant's scope of practice is identified; (2) the delegation of medical tasks is appropriate for the physician assistant's level of competence; (3) the relationship and access to the supervising physician is defined, and (4) a process of evaluating the physician assistant's performance is established. The physician assistant and the supervising physician may designate back-up supervising physicians to supervise the physician assistant when the supervising physician is unavailable.

Prescriptive and Other Delegatory Authority

Supervising physicians may delegate prescriptive authority to their physician assistants and may delegate other duties and responsibilities. The supervising physician must be identified on

all prescriptions and orders generated by the physician assistant.

See also, Physician Assistants, Scope of Authority, 205.
Ark. Code Ann. § 17-105-101 and following; Arkansas Medical Board Reg. 24.

See also, Drugs-Controlled Substances, Schedules of Controlled Substances at page 64.

PODIATRY

The definition of "podiatric medicine" includes the diagnosis and treatment of ankle ailments, as well as ailments of the foot. Treatment occurs by medical, mechanical, or surgical means. The law prohibits podiatrists from amputating a human foot, performing nerve or vascular grafting, or administering any anesthetic other than a local anesthetic. All ankle surgery performed above the level of the foot other than skin and skin structures must be done in a facility accredited by either Medicare or by the Joint Commission on Accreditation of Health Care Organizations.

The practice of podiatry is overseen by the Arkansas State Podiatry Examining Board. Similar to the Arkansas State Medical Board, the State Podiatry Examining Board issues licenses to those qualified to practice podiatry. The practice of podiatry requires qualifications comparable to the prerequisites necessary for the practice of medicine. Likewise, podiatrists must pass an examination prior to receiving license registration and must attend continuing professional education courses to maintain the license.

A 2009 change in the law enables podiatrists to delegate some simple procedures to unlicensed employees. See Delegated Medical Procedures at Page 63.
Ark. Code Ann. §§ 17-96-101 to 308, as amended by Act 472 of 2009.

PRESCRIPTIONS

Physician Dispensing Act

Under Arkansas law, a dispensing physician must personally dispense legend drugs (drugs that require a prescription) and may not delegate the task to someone else, unless authorized by law, e.g., to physician assistants. A "dispensing physician" is one who purchases legend drugs for a patient's use outside the physician's office. Physicians must apply with, and be approved by, the Arkansas State Medical Board before they can become dispensing physicians.

The law imposes a duty on the physician to keep records of all receipts and distribution of legend drugs for possible inspection by the Arkansas State Medical Board. In addition, the physician must label each legend drug with the patient's name and address, the prescribing physician's address and narcotic registry number, date of dispensing, directions for administering, and precautions if applicable.
Ark. Code Ann. § 17-95-102.

See Delegated Medical Procedures at Page 63.

Contents and Labels

On request by the patient, a physician must indicate the condition for which the medication is being prescribed. Any pharmacist dispensing the prescription must include on the label all information stated on the prescription.

Labels on original packages must bear the name of the distributor or manufacturer. If the medication is one used internally, the proper dose must also be indicated.

Poisons should bear a readily apparent "POISON" label. The antidote for a poisonous dose should likewise be indicated.

Ark. Code Ann. § 17-92-411.

Prescription of Depressants and Stimulants

Physicians and health facilities may prescribe, dispense, or administer depressant or stimulant drugs during the course of business.

Duty to Keep Records

If a physician regularly sells depressants or stimulants to his or her patients, the physician must maintain records for at least three years. The records must include the kind and quantity of drug received or sold, the name and address from whom the drug was received, the name and address to whom the drug was sold, and the date of the transaction.

Limitations on Filling of Prescription

Depressant and stimulant prescriptions must expressly state the refill status before the prescription may be refilled. No prescription may be filled or refilled more than six months after it was issued. No prescription may be refilled more than five times. The physician may, however, issue a new written or oral prescription at any time.

Investigation and Inspection

The Department of Health may conduct examinations, investigations, or inspections when depressant or stimulant drugs are sold or prescribed.

Violations and Penalties

Physicians commit a felony if they fail to maintain proper records, refuse to permit access or copying of records when investigated or inspected, violate the requirements governing the filling and refilling of prescriptions, or dispense counterfeit depressants or stimulants. On conviction, the physician faces a fine of not more than $2,000, or imprisonment up to two years or both. A second conviction results in a fine of not more than $2,000 and imprisonment for three to five years. A third or subsequent conviction results in a fine of not more than $5,000 and/or imprisonment for five to ten years.

Ark. Code Ann. §§ 20-64-301 to 317.

Prescription of Narcotics

Physicians may prescribe, administer, and dispense narcotics in the regular course of business for scientific or medicinal purposes. Physicians must obtain narcotic drugs from licensed manufacturers or wholesalers by official written orders, which are defined as an order written on a form from the Drug Enforcement Agency, or if no such federal form is required,

then the order must be written on a form from the Arkansas Department of Health.

Other Requirements

Official written orders must be signed in quadruplicate by the physician or his or her agent. The original must be presented to the dispenser of the narcotic. One copy must be filed with the Director of the Department of Health no later than the 10th day of the month following the date the narcotic was ordered. Copies of the official written order must be maintained for two years by both the physician and the dispenser.

Apothecaries

"Apothecaries" may dispense narcotic drugs prescribed by a physician. An apothecary is a licensed pharmacist who owns a business where narcotics are compounded or dispensed by a licensed pharmacist. The prescription must contain the date of issue, the name, address, federal registry number and signature of the prescribing physician, and the name and address of the patient. The prescription must remain on file at the pharmacy for two years and may not be refilled.

Upon official written order, an apothecary may sell an aqueous or oleaginous solution containing no more than 20% narcotic content. No more than one ounce may be sold at any one time.

Exempted Preparations

Certain preparations are exempted from the above requirements. These preparations include those drugs determined by the Department of Health as non-addictive or not dangerous to the public.

Also included are certain preparations containing codeine which are sold for medicinal purposes. Exempted codeine preparations are those containing no more than one grain of codeine (or any of its salts) in one fluid ounce or one avoirdupois (based on a pound equaling 16 ounces) solid or semi-solid ounce. Further, the codeine preparation must contain drugs conferring "medicinal qualities other than those possessed by the narcotic drug alone."

Using fraud or deceit in obtaining or administering exempted preparations results in a fine from $25 to $100.

Duty to Keep Records

Physicians must keep a record of all narcotic drugs they receive. The record must include the date of receipt, name and address of the deliverer, quantity and kind of drug received, and the proportion of codeine, morphine, or ecgonine contained in or producible from received opium or coca leaves.

A record of all narcotic drugs administered, dispensed, or professionally used must also be kept. The record must include the date of sale or administration, the name and address of the patient, and the quantity and kind of drug.

Records of small quantities of narcotic preparations used for local application need not include the amount applied to each individual patient. Records must be kept, however, of the quantity, character, and potency of the preparation, and the date of purchase or preparation.

A record of cannabis purchased for resale must be kept. The record needs to include the date of receipt, name and address of the person received from, and the proportion of resin contained in or producible from the plant.

All records must be kept for at least two years after the date of transaction. Records kept in

accordance with federal law generally fulfill state responsibilities.

Records maintain a shield of confidentiality that can only be pierced by officers enforcing narcotic laws. Officers may not divulge information outside of proceedings before a court or licensing board.
Ark. Code Ann. § 20-64-201 to 220.

Penalties

Physicians commit a felony if they fail to follow the state laws on the prescription of narcotics or use fraud or deceit while fulfilling their responsibilities. State felony conviction results in a fine of not more than $2,000 and imprisonment for two to five years. A second conviction or a first conviction with an earlier narcotic or marijuana-related conviction, results in a fine of not more than $2,000 and imprisonment for five to ten years. Third and subsequent offenses result in a fine of not more than $2,000 and imprisonment for ten to twenty years. Probation or parole will not be granted until the minimum time of imprisonment has been served.

Physicians who prescribe drugs that are not for legitimate medical purposes and are not in the usual course of their medical practices also violate the drug abuse prevention chapter of the federal Food and Drug Act. Therefore, a physician may be prosecuted under both state and federal law and subject to two sets of penalties for the same offense.
21 U.S.C. § 841.

Notice of Conviction

Upon conviction for violation of the laws regulating narcotics, the Arkansas State Medical Board receives a copy of the judgment, sentence, and opinion of the court. The court may suspend or revoke a physician's license. The physician may apply to the board for reinstatement of his license.
Ark. Code Ann. § 20-64-215.

Inspections by Arkansas State Medical Board

Investigators from the Division of Pharmacy Services and Drug Control of the Department of Health, on behalf of the Arkansas State Medical Board, possess the authority to investigate, inspect, and copy records, orders, and prescriptions. Copies of prescriptions do not become public records if used in a disciplinary hearing. Further, physicians and patients maintain property rights to copied prescriptions.
Ark. Code Ann. § 17-95-304; 17-80-106.

Generic Drug Substitution

With certain restrictions, pharmacists may dispense lower-priced generically equivalent drugs when receiving a prescription for a brand or trade-name drug. The Arkansas State Board of Pharmacy shall determine which drugs are generically equivalent, relying on generally accepted standards in the field of pharmacy.

Physician Instructions

Pharmacists may not dispense generically equivalent drugs when the prescription indicates that no substitutions should be made. If the prescription is in writing signed by the prescriber, then the prescriber must indicate "in his or her own handwriting by name or initial" that no substitution can be made. If the prescription is not in writing signed by the prescriber, then the

prescriber must "expressly indicate" that the prescription is to be dispensed as communicated. The person receiving the drug may also indicate that no substitution should be made. Also, no substitution may be made if the State Pharmacy Board has determined that the drug should not be substituted and has notified pharmacists of its decision.
Ark. Code Ann. § 17-92-503.

Labels

Pharmacists must include certain specified information on the label of dispensed drug products. When dispensing generic drugs, the label must indicate the generic name of the medication and the manufacturer of the medication. The pharmacist must also inform the patient of the generic equivalent or expressly indicate substitution on the label.

Information on generic substitution is not always required. Hospitals need not inform inpatients of generic substitution. Also, physicians may "indicate that the name, manufacturer, and strength of the medication dispensed . . . be deleted from the label."
Ark. Code Ann. §§ 17-92-501 to 503, 505-506.

Internet and Electronic Mail Prescriptions

Arkansas law provides that pharmacies selling or otherwise participating in the dispensing of prescription-only drugs are prohibited from engaging in Internet or electronic mail dispensing unless the pharmacy meets certain requirements. It is the position of the federal Drug Enforcement Agency that no prescriptions for drugs on Schedules II through V may be made through electronic transmission at the present time. However, the DEA has issued proposed rules that would allow electronic prescribing for controlled substances; as of this date, those regulations have not been finalized. Facsimiles are not considered electronic transmissions, which generally are defined in terms of computer-to-computer transmissions. ***See Electronic, Facsimile and Oral Prescriptions at page 72; Electronic Prescriptions for Controlled Substances at page 74; Electronic Prescriptions Under Medicare Part D at page 77.***

Federal Law. Although the DEA does not allow electronic prescribing for controlled substances, it has issued regulations pursuant to the Ryan Haight Online Consumer Protection Act to regulate the sale of controlled substances over the Internet. The regulations require that a patient has been seen in person by the practitioner who writes the prescription, although there are certain exceptions for telemedicine as described below. The regulations require that an online pharmacy must first be a DEA-registered pharmacy that then obtains DEA approval to engage in online dispensing of prescriptions. The online pharmacy's website must state clearly that it is in compliance with federal law and must post the name and address of the pharmacy, the pharmacy's telephone number and email address, the name of the pharmacist-in-charge and a number at which he or she can be contacted, a list of the states in which the pharmacy is licensed to dispense controlled substances. The pharmacy is also required to comply with any state licensure requirements in each state to which it delivers, distributes, or dispenses controlled substances by means of the internet. Once the DEA regulations on electronic prescribing are finalized, pharmacies whose business consists solely of filling electronic prescriptions will be exempt from the provisions of the Ryan Haight Act.

State Law. Under current state law on Internet and e-mail prescriptions, a participating pharmacy must be in compliance with all mandates of federal and state law applicable to both the web site and to electronic mail used in the sale of prescription-only drugs. The pharmacy must be regulated by the Arkansas Board of Pharmacy. If the pharmacy is outside Arkansas, it still must

hold a license from the Arkansas Board of Pharmacy if it routinely ships, mails, or delivers a dispensed legend drug into Arkansas. Additionally, any practitioner who sells, dispenses, distributes, or delivers prescription-only drugs must be in compliance with all requirements of relevant state law. If a practitioner writes a prescription order through an Internet site or electronic mail for a consumer physically located in Arkansas, who is not an established patient, the practitioner must be licensed by the applicable licensing board and in compliance with all applicable laws. Changes to the law in 2009 set out new requirements for a proper practitioner-patient relationship before the issuance of a prescription: a practitioner, physician, or other prescribing health professional must perform a history and in-person physical examination of the patient adequate to establish a diagnosis and to identify underlying conditions or contraindications to the treatment recommended or provided, unless the prescribing practitioner is seeing the patient at the request of another practitioner who maintains an ongoing relationship with the patient, or the prescribing practitioner is interacting with the patient through on on-call or cross-coverage situation.

Under changes to the law in 2007, a pharmacist may not fill a prescription to a patient if the pharmacist knows or reasonably should have known that the prescription was issued on the basis of an Internet questionnaire, an Internet consultation, or a telephonic consultation and without a valid patient-practitioner relationship.

Internet pharmacies must disclose certain information on their web sites, including the pharmacists and physicians associated with the site, the name, address, and telephone number of each participating pharmacy, as well as the pharmacy's permit number or certification by the National Association of Boards of Pharmacy (NABP) as a Verified Internet Pharmacy Practice Site (VIPPS).

Internet pharmacies may not disclaim or limit liabilities to which they otherwise are subject under law for the act or practice of selling, dispensing, or delivering prescription-only drugs. Any disclaimer or limitation is void and constitutes a violation of the law. Any violation of this law is an unconscionable trade practice under state law.

Ark. Code Ann. § 17-92-1001 and following, as amended by Act 128 of 2007, and Act 355 of 2009; the Ryan Haight Act, Pub. L. 110-425 and implementing regulations..

"Telemedicine"

Under the Ryan Haight Act, a practitioner engaged in the practice of telemedicine is exempt from the requirement of an in-person medical evaluation as a prerequisite to prescribing or otherwise dispensing controlled substances over the Internet. The definition of "telemedicine" requires that the practice fall within one of seven categories: (1) treatment in a hospital or clinic, (2) treatment in the physical presence of a practitioner, (3) treatment by a practitioner who is an employee or contractor of the Indian Health Services, (4) treatment during a public health emergency, (5) treatment by a practitioner who has obtained special registration from the DEA Administrator, (6) emergency treatment by a Department of Veterans Affairs employee, or (7) treatment under other services established by regulation. *21 Code of Federal Regulations § 1300.04(i).*

See also Electronic Prescriptions for Controlled Substances at 74; Electronic Prescriptions under Medicare Part D at 77; Licensing, Physician; Grounds for Denial, Suspension, or

Revocation; Proper Patient Relationships Prior to Treatment at page 148; Telemedicine at page 239.

Dispensing of Donated Prescription Medications

In 2005, the General Assembly approved a pilot program authorizing charitable clinics with outpatient pharmacies to redispense certain medicines that would otherwise be destroyed. The Arkansas State Board of Pharmacy, in cooperation with the Department of Health and the Department of Human Services, must develop and implement a program for transfer of unused prescription medications from a nursing facility to a charitable clinic pharmacy for redispensing to indigent patients. However, controlled substances would not be redispensed under this program. Participation in this program by any entity, including individuals, charitable clinics, pharmacies, nursing facilities, and drug manufacturers would be voluntary. Prescribing physicians and certain other participants in the pilot program would not be subject to any professional disciplinary action or criminal prosecution for actions taken under the program. Also, participation in the program could not be used as an independent basis for a claim of liability in a civil lawsuit.

Ark .Code Ann. § 17-92-1101 and following.

See also Drugs - Controlled Substances at page 64; Electronic, Facsimile and Oral Prescriptions at page 72; Electronic Prescriptions for Controlled Substances at page 74; Electronic Prescriptions under Medicare Part D at page 77.

PRIVILEGED COMMUNICATION BETWEEN PHYSICIAN AND PATIENT

The privileged communications discussed in this section concern whether certain physician-patient communications can be admitted into evidence during a court proceeding. ***See HIPAA at page 115 for general confidentiality rules.***

The Arkansas Rules of Evidence provide that in certain circumstances during a legal proceeding, a patient may refuse to divulge information in his medical record or to divulge "confidential" communications made for the purpose of diagnosis and treatment of his physical, mental, or emotional condition. The patient is the holder of the privilege, and the privilege covers communications between the patient and his physician or psychotherapist and other persons participating in diagnosis and treatment under the direction of the physician or psychotherapist. The patient may prevent these persons from divulging this information. A communication is confidential if disclosure to third persons is not intended.

This privilege also may be claimed on behalf of the patient by the patient's physician or psychotherapist, guardian or conservator, or personal representative if the patient has died.

There are three exceptions to the privilege rule under the applicable Arkansas Rules of Evidence. First, communications in a proceeding to hospitalize the patient for mental illness are not privileged. Second, communications made in court-ordered examinations of a patient's physical, mental, or emotional condition are not privileged. And third, communications about a patient's physical, mental, or emotional condition are not privileged when the patient relies on the condition as a claim or defense in a legal proceeding.

A patient waives this privilege when he voluntarily discloses a "significant part of the privileged matter." However, privilege is not waived when the patient has been compelled to disclose privileged information by mistake, nor when the patient did not have the opportunity to claim privilege.

Ark. Rules of Evidence 503; 510; 511.

The legislature extended the physician-patient privilege to patients' confidential communications with dentists and pharmacists. But practitioners should be wary of relying on this. The Arkansas Supreme Court has previously recognized legislation in this area only when the legislation is compatible with its own rules, and if conflict arises between the court's rules and legislative rules, the court's rules are supreme. Therefore, the law extending the privilege to communications with dentists and pharmacists ultimately may be declared unconstitutional.

Ark. Code Ann. § 16-41-101; Ark. Rule of Evidence 503; State v. Sypult, 304 Ark. 5, 800 S.W.2d 402 (1990).

RABIES

State, county, and city health authorities and law enforcement officials possess the duty to confine animals suspected of having rabies. Physicians should notify these officials of any information concerning persons bitten by animals suspected of having rabies.

The Arkansas Department of Health handles all testing of suspected animals. Animals submitted for testing must be accompanied by personal information on the person possibly exposed to rabies and the name of his attending physician. The testing lab reports the finding to the attending physician, veterinarian, local health unit, or victim.

Physicians must report any information concerning a person bitten by a dog, cat, or other animal to the Department of Health authorities. Failure to report may result in a misdemeanor charge carrying a fine of $5 to $25.

Presently, the Department of Health is revising the rules and regulations pertaining to rabies control. The draft of the rules from July 2009 updates definitions, revises quarantine provisions, updates instructions for shipping specimens to the public health laboratory for testing, modernizes vaccination requirements, and deletes the misdemeanor conviction fine. The draft has a provision to allow the Board of Health to access civil penalties up to $1,000 for each violation. Under this provision, each day of a continuing violation could be deemed as a separate violation.

Ark. Code Ann. §§ 20-19-301 to 312, as amended by Act 159 of 2009; Ark. Dept. of Health Rules and Regulations Pertaining to Rabies Control (1975) (Draft revisions 07/2009).

RADIATION HEALTH AND SAFETY

Under the Arkansas Consumer- Patient Radiation Health and Safety Act, only those persons who are "licensed practitioners," radiologic technologists, licensed technologist, or limited licensed technologists are permitted to use radioactive materials or medical equipment that emits or detects ionizing radiation for diagnostic or therapeutic purposes on humans. "Licensed practitioners" include those licensed to practice medicine, dentistry, podiatry, chiropractic, osteopathy or optometry in Arkansas. A "licensed technologist" means a person other than a licensed practitioner who uses radioactive materials or medical equipment that emits or detects ionizing radiation under the supervision of a licensed practitioner and who is "grandfathered" under the law.

The law defines many terms, including "limited license," "limited license technologist," "medical dosimetrist," "nuclear medicine technologist," and "radiation practitioner."

The Medical Ionizing Radiation Licensure Committee grants, denies, renews, suspends or revokes licenses. The Committee may also conduct disciplinary proceedings. Any license issued by the Committee may be suspended or revoked, or the individual may be censured, reprimanded, or otherwise sanctioned by the committee if the individual (1) has been found guilty of fraud or deceit in the procurement or holding of the license; (2) has been convicted of a felony; (3) is or has been afflicted with any medical problem, disability, or addiction that would impair professional competence; (4) has knowingly aided a person who is not a radiologic technologist in performing duties of a license holder; (5) has engaged in any practice beyond the scope of duties permitted a license holder; (6) has impersonated a license holder; (7) has violated

the board's code of ethics; (8) has applied ionizing radiation without a prescription; (9) has interpreted a diagnostic image for a fee; (10) has been found guilty of incompetence or negligence in performance as a license holder, or (11) has failed to comply with the applicable law or rules.

Among those exempted from coverage under the Consumer-Patient Radiation Health and Safety Act are dentists, dental hygenists, radiation health physicists, radiation medical physicists, chiropractic externs, bone densitometrists, and certified medical dosimetrists. Nothing in this chapter relating to radiologic technology shall limit, enlarge, or affect the practice of licensed practitioners defined herein.*Ark. Code Ann. § 17-106-101 and following, as amended by Act 827 of 2007 and Act 1375 of 2009.*

REPORTING, MANDATORY PHYSICIAN

Abortions

Physicians who perform abortions must report to the Department of Health certain information required by the 2005 Unborn Child Pain Awareness and Prevention Act. Physicians are required to list the number of women who were provided the fetal pain information required by the Act, and of that number, to list the number who were provided the information by phone and the number provided it in person. The report must indicate whether the information was provided by the physician who performed the abortion or by an agent of the physician. The report must also state: the number of women who did not choose to get a printed copy of information on fetuses and pain; the number who obtained abortions; the number of "immediate" abortions performed by the physician without providing the required information because the abortion was needed to prevent the mother's death, and the number of abortions performed without providing the information at least 24 hours in advance of the abortion because the delay would have created a serious risk of a substantial and irreversible bodily impairment of a major bodily function of the woman. A physician who fails to timely submit the reports may be fined $500 for each 30-day period, or portion thereof, that a report is overdue. If a physician has failed to submit a report or has submitted an incomplete report more than one year after the due date, the Department of Health may seek a court order to compel the physician to prepare or complete the report. The physician may be held in civil contempt of court and fined. *Ark. Code Ann. § 20-16-1108.*

Abuse of Adults

Adults protected from abuse are endangered or impaired persons *regardless of their age*, all long term care residents and patients at the Arkansas State Hospital. For purposes of this law, all residents of long term care facilities are presumed to be "impaired."

The law requires physicians and others to report suspected abuse of any person in one of these groups. However, if a health care provider sees a patient who has been injured through domestic violence, the provider does not have to report this incident if: (1) the provider determines the patient understands how the injury occurred and the patient has the ability to choose to avoid the situation in the future and (2) the patient is not a resident of a long term care facility. If the person is "endangered" or "impaired", as defined below, a report must be made.

Physicians also have reporting requirements if they have reasonable cause to suspect that an person in one of the covered groups has died as a result of maltreatment.

Definitions

"Abuse" is defined as any purposeful or intentional unnecessary physical act which inflicts pain, or causes injury to an endangered or impaired person; or any purposeful or intentional or demeaning act that a reasonable person would believe subjects an endangered or impaired person, regardless of age, ability to comprehend, or disability, to ridicule or psychological injury in a "manner likely to provoke fear or alarm", or any intentional threat that a reasonable person would find credible and non-frivolous to inflict pain on or cause injury to an endangered or impaired person, except in the course of medical treatment or for justifiable cause. With regard to a resident of a ***long-term care facility*** or the ***Arkansas State Hospital***, "abuse" means any of the above acts, excluding court-ordered or legally authorized medical care, and it includes purposeful or willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.

"Adult maltreatment" means abuse, exploitation, neglect, physical abuse or sexual abuse of an adult.

"Long term care facility resident maltreatment" is the abuse, exploitation, neglect, physical abuse or sexual abuse of any facility resident, regardless of age.

"Endangered person" means an adult 18 years of age or older, or a resident of any age of a ***long term care facility***, who is found to be in a situation or condition which poses an imminent risk of death or serious bodily harm, and who lacks the capacity to comprehend the nature and consequences of remaining in that situation or condition.

"Impaired person" means a person 18 years of age or older who, as a result of mental or physical impairment, is unable to protect himself from abuse, sexual abuse, neglect or exploitation. Residents of a ***long-term care facility***, regardless of age, are presumed to be impaired persons.

"Exploitation" means "the illegal or unauthorized use or management of an endangered or impaired person's funds, assets, or property" or the improper use of an endangered or impaired adult's power of attorney or guardianship by someone for the profit or advantage of himself, herself or another. It also includes misappropriation of property of a resident of a long-term care facility, which means deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent.

"Neglect" means acts or omissions by a caregiver that constitute negligent failure "to provide necessary treatment, rehabilitation, care, food, clothing, shelter, supervision, or medical services" to an endangered or impaired adult; negligent failure "to report health problems or changes in the health condition" of an endangered or impaired adult to appropriate medical personnel; negligent failure "to carry out a prescribed treatment plan", or negligent failure to provide goods and services needed to avoid physical harm, mental anguish, or mental illness to a resident of a ***long-term care facility***. It also means acts or omissions by an endangered or impaired person, such as self-neglect.

"Sexual abuse" means deviate sexual activity, sexual contact, or sexual intercourse, as defined in the state criminal code, with another person who is not the actor's spouse and who is incapable of consent because he or she is mentally defective, mentally incapacitated or physically helpless, as defined in the criminal code.

"Long-term care facility" means a nursing home, residential care facility, post-acute head injury retraining and residential facility, any facility that provides long-term medical or personal care, an intermediate care facility for the mentally retarded or an assisted living facility.

"**Caregiver**" means any person or agent or owner of a public or private organization, or the public or private organization itself, that has the responsibility for protection, care or custody of

an endangered or impaired person.

What Happens after a Report is Made

The Arkansas Department of Human Services, and sometimes the state Attorney General's office and/or local law enforcement, investigate allegations of maltreatment of adults and long term care residents. After an investigation and an opportunity for a hearing, DHS will determine whether the accusation is "founded", meaning it is supported by a preponderance of the evidence. Those persons who have "founded" reports against them will be listed in DHS' statewide Central Registry of adult abusers. Caregivers with a "founded" report against them may be sued by the state for a civil monetary penalty. . ***Ark. Code Ann. § 12-12-1701 and following, as amended by Acts 283 and 497 of 2007 and Acts 165 and 52of 2009.***

Emergency Custody. Before an investigation is completed, DHS may taken action for immediate removal of the adult if necessary for protection from imminent danger to his or her health or safety. **See Adult Abuse at page 23.** *Ark. Code. Ann*. ***§ 9-20-101 and following.***

Who is Required by Law to Report

Those required by law to immediately report abuse of an endangered or impaired person or of a long term care resident if they have observed or have reasonable cause to suspect maltreatment include physicians, coroners, dentists, osteopaths, resident interns, nurses, social workers, home health workers, mental health professionals, emergency medical technicians, facility administrators, owners and employees, employees of the Department of Human Services, hospital personnel engaged in the administration, examination, care or treatment of persons, and employees of banks and other financial institutions. Whenever a person required to report is a member of the staff or an employee of a facility or of a department, he must notify the person in charge of the facility or his designated agent, who shall then become responsible for ensuring a report is made within twenty-four (24) hours or on the next business day, whichever is earlier.

Immunity

Any person, physician, or institution acting in good faith in making a report, taking of photographs, or the removal of a maltreated person or adult under the law has immunity from liability and suit for damages, civil or criminal. The good faith of any person required to report cases of adult or long term care facility resident maltreatment shall be presumed.
Ark. Code Ann. § 12-12-1713; Ark. Code Ann. § 9-20-107, as amended by Act 526 of 2009.

Penalty for Failure to Report

Any person or caregiver who is required to report suspected adult maltreatment under this law and who knowingly fails to properly do so may be charged with a Class B or C misdemeanor and may be liable for monetary damages in an amount consistent with the harm suffered by the abused person as a result of the failure to report. Knowingly making false allegations of abuse is a crime as well, and depending on the circumstances, can constitute a Class A misdemeanor or a Class D felony.

How to Report

If the person does not reside in a long term care facility, reports of suspected maltreatment should be made to the Department of Human Services' adult maltreatment hotline at the following telephone number, available 24 hours a day, seven days a week: (800) 482-8049 or to

(501) 682-8491.

If the person does live in a long term care facility, the report must be made immediately to the local law enforcement agency where the facility is located and to the state Office of Long Term Care of the Division of Medical Services of DHS.

Processing of report. The initial report may be made immediately available to local law enforcement. Allegations of maltreatment are accepted by DHS if the allegations, if true, would constitute adult maltreatment under the law and as long as sufficient information is provided to identify and locate the potential victim.

Confidentiality of reporter. DHS is prohibited from releasing information that would identify the person making the report unless a court orders release of the information after reviewing it and determining the release is needed to prevent a crime or to prosecute a crime. The information provided to the alleged offender about the accusation of maltreatment generally will not include the name of the reporter. Any person who willfully permits or who encourages the improper release of information from reports of maltreatment can be charged with a Class A misdemeanor.

Duty to Report Deaths

Medical care providers and emergency personnel who are mandatory reporters of suspected abuse are also under a duty to report any death when the suspected cause is maltreatment. The report must be made to the medical examiner or coroner.

In all cases of the death of a resident of a ***long-term care facility*** resident or a hospice resident, the facility or hospice must immediately report the death to the coroner even if the death is from natural causes. In all cases of the death of a person in a hospital who was a resident of a long-term care facility within five days of entering the hospital, the hospital must report the death to the coroner, even if the death is from natural causes. Any person who is required to report a death as the result of suspected adult abuse or suspected maltreatment of a long term care resident, and who knowingly fails to make a report immediately to the appropriate coroner, can be charged with a Class C misdemeanor.

Photographs and X-rays

Physicians or any other mandatory reporter, at public expense, must take color photographs of areas of physical trauma, and if medically appropriate, x-rays. The photographs and x-rays must be sent to DHS as soon as possible.

Ark. Code Ann. §§ 12-12-1712. .

See also Abuse, Maltreatment of Adults at page 23.

Child Maltreatment

Physicians and certain medical care practitioners are required by law to report suspected abuse or neglect of a child. In 2009, the law on child maltreatment was revised in several ways, including changing the penalties for failure to report, making additions to the confidentiality provisions, and clarifying that certain medical records must be provided at no cost to the Arkansas Department of Human Services or to law enforcement. The 2009 version of the law also provides for the Child Abuse Hotline to accept reports on adult victims, in certain circumstances. It also gives DHS the authority in some cases to pursue medical treatment for the child.

What Happens after a Report is Made

Arkansas DHS, the Crimes Against Children Division of the Arkansas State Police and sometimes local law enforcement investigate allegations of child maltreatment. After the investigation and an opportunity for a hearing, DHS will determine whether the accusation is "true", meaning it is supported by a preponderance of the evidence. With some exceptions, those persons who have "true" reports against them will be listed in DHS' statewide Child Maltreatment Central Registry of persons who have maltreated children.
Ark. Code Ann. §12-18-901 and following.

Under the old version of the law, DHS provided the physician who reported the maltreatment with information regarding the investigative findings and the services that were offered and provided. Under the current version of the law, the mandatory reporter will receive a notification only if the investigation determination is "unsubstantiated."
Ark. Code Ann. § 12-18-708.

When a Physician is Required by Law to Report

If physicians and certain other persons have "reasonable cause to suspect" child maltreatment, or that a child has died as a result of maltreatment or have observed a child "being subjected to conditions or circumstances that would reasonably result in child maltreatment," they must immediately notify the child abuse hotline, as explained below. Among the numerous other professions required to report suspected or observed child maltreatment are: any medical personnel engaged in admission, examination, care, or treatment of persons; resident interns, licensed nurses, dentists, dental hygienists, osteopaths, mental health professionals, and coroners.

Communications between the offender and physicians, psychiatrists, psychologists, licensed counselors or therapists or any medical personnel about such abuse are not protected by privilege or by contract. Therefore, if these persons learn that their patient has committed child maltreatment, they must report it to DHS or to a law enforcement official.
Ark. Code Ann. § 12-18-402, as amended by Act 749 of 2009.

Additional Reporting under Garrett's Law. The definition of "neglect" include causing a "newborn child to be born with an illegal substance present in the newborn's bodily fluids or bodily substances as a result" of the mother's knowingly using an illegal substance prior to the newborn's birth or causing the child to be born with "a health problem as a result of" the mother's use before birth of an illegal substance. An "illegal substance" is "a drug that is prohibited to be used or possessed without a prescription under the Arkansas Criminal Code." Tests of the mother's or child's bodily fluids or substances may be used as evidence. The Child Abuse Hotline can only accept reports of suspected neglect based on Garrett's Law if the reporter has "reasonable cause" to suspect this kind of neglect and if the reporter is one of the following mandatory reporters: physician, surgeon, licensed nurse, "any medical personnel engaged in the admission, examination, care or treatment of persons", an osteopath, a resident intern, or a social worker in a hospital.
Ark. Code Ann. §12-18-305.

Additional Reporting on Certain Abortions. When performing abortions on unemancipated minors, the attending physician must report abuse if a pregnant minor avoids obtaining parental consent for the abortion by submitting an affidavit stating her only living parent has committed incest with her, raped her or otherwise sexually abused her.
Ark. Code Ann. § 20-16-808, as amended by Act 758 of 2009.

See Abortion, Parental Consent Requirements at page 98.

Immunity

Any mandated reporter who acts with a good faith belief that maltreatment has occurred is immune from civil and criminal liability and suit for damages for making a report or taking a photograph or radiological test. *Ark. Code Ann. § 12-18-107.*

Penalty for Failure to Report

The 2009 version of the law creates two levels of penalties for a mandatory reporter's failure to report. It is a Class A misdemeanor for a mandatory reporter to "knowingly" fail to report child maltreatment when the mandatory reporter has reasonable cause to suspect child maltreatment or a a child's death due to maltreatment, or when a mandatory reporter observes a child being subjected to conditions or circumstances that would reasonably result in child maltreatment. "Recklessly" failing to report maltreatment is a Class C misdemeanor. A Class A misdemeanor is punishable by a fine not exceeding $2,500.00 and a sentence not exceeding one year. Class C is punishable by a fine not exceeding $500.00 and a sentence not exceeding 30 days.

Persons who are required to report child maltreatment who "purposely" fail to do so are civilly liable for damages proximately caused by that failure to report.
Ark. Code Ann. § 12-18-201, 12-18-202, 12-18-206; 5-4-201, 4-4-401.

How to Report

Suspected child maltreatment must be reported to the Department of Human Services child abuse hotline, which is available 24 hours a day, seven days a week: (800) 482-5964. Persons who are required to report child maltreatment or suspected child maltreatment may report by telephone call, or in non-emergency situations by facsimile at (501) 618-8952.
Ark. Code Ann. §12-18-301, 302

Confidentiality

DHS shall not release information identifying the person who made the report unless a court orders the release after the court has reviewed the information and found it has reason to believe the reporter knowingly made a false report. However, this information may also be disclosed to the prosecuting attorney or law enforcement upon request. A person or agency whom receives this disclosure must not disclose the information to any other person. It is a crime for a person to knowingly disclose information about the alleged child maltreatment to another person who is not entitled under the law to receive such information.*Ark. Code Ann. §12-18-502, 205 and 209.*.

Definitions

A **"child"** or **"juvenile"** is one who is under the age of 18 years.

"Child maltreatment" is defined as abuse, sexual abuse, neglect, sexual exploitation, or abandonment when committed by a parent and certain designated persons. ***See also, Abandonment of Newborn at page 33.*** However, acts or omissions by the *spouse* of a minor do not fall within the definition of child abuse or neglect.

"Abuse" is defined as any of the following acts or omissions by a parent, guardian, custodian, foster parent, person eighteen (18) years of age or older living in the home with a child whether related or unrelated to the child, or any person who is entrusted with the child's care: extreme or repeated cruelty; conduct that creates a realistic and serious threat of death, disfigurement, or

impairment of an organ; injury to a child's intellectual, emotional, or psychological development evidenced by observable, substantial functional impairment; injury that varies from the history given; and certain kinds of nonaccidental physical injuries.

The following are examples of acts that constitute abuse, where the intentional conduct results in physical injury and there was no justifiable cause: throwing, kicking, burning, biting, shaking, or cutting a child; striking a child with a closed fist, and striking a child on the face or head. The examples of intentional acts constituting abuse, *whether or not the acts result in physical injury*, are striking a child age six or younger on the face or head; shaking a child age three or younger; interfering with a child's breathing; pinching, biting, or striking a child in the genital area; tying a child to a fixed or heavy object or binding or tying a child's limbs together; giving or permitting a child to consume or inhale a poisonous or noxious substance not prescribed by a physician that has the capacity to interfere with normal physiological functions; giving or permitting a child to consume or inhale a substance not prescribed by a physician that has the capacity to alter the mood of the child, such as alcohol, narcotics, marijuana, and in certain situations, over-the-counter drugs; exposing a child to chemicals that have the capacity to interfere with normal physiological functions, such as chemicals used or generated during the manufacture of methamphetamine; and subjecting a child to Munchausen's Syndrome by Proxy or a Factitious Illness by Proxy if the incident is reported and confirmed by medical personnel or a medical facility.

Physical discipline or restraint of a child is not considered abuse when it is "reasonable and moderate" and is inflicted by a parent or guardian and when it is not likely to cause and does not cause injury that is more serious than transient pain or minor temporary marks. When the person restraining the child is an employee of an agency licensed or exempted from licensure under the Child Welfare Agency Licensing Act, restraint which results in transient pain or temporary marks is not abuse, if: (a) the agency has policies and procedures regarding restraints; (b) no other alternative exists to control the child except for restraint; (c) the child is in danger or hurting himself or herself or others; (d) the person exercising the restraint has been trained in properly restraining children, de-escalation, and conflict resolution techniques; (d) the restraint is for a reasonable period of time; and (e) the restraint is in conformity with training and agency policies and procedures. In all cases, the age, size, and condition of the child and the location of the injury and the frequency or recurrence of injuries must be considered when determining whether the physical discipline is reasonable or moderate.

Whether an act is **"sexual abuse"** sometimes depends on the age and relationship of the persons and whether forcible compulsion is used:

- When committed by a person 10 years of age or older, to a person younger than age 18, sexual abuse includes actual or attempted sexual intercourse, deviate sexual activity, or sexual contact by forcible compulsion; indecent exposure or forcing the watching of pornography or live sexual activity.
- When committed by a person 18 years old or older to a person not his or her spouse who is younger than 16 years old, sexual abuse is defined as actual or attempted sexual intercourse, deviate sexual activity, or sexual contact.
- When committed by a caretaker to a person younger than 18, sexual abuse is defined as actual or attempted sexual intercourse, deviate sexual activity, or sexual contact; forcing or encouraging the watching of pornography, permitting or encouraging the watching of live sexual activity, forcing the listening to a phone sex line, or an act of voyeurism.
- When committed by a person younger than 10 years of age to a person younger than

18 years of age, sexual abuse is defined as actual or attempted sexual intercourse, deviate sexual activity, or sexual contact by forcible compulsion.

"Pornography" means pictures, movies, or videos that lack serious literary, artistic, political or scientific value and that, when taken as a whole and applying contemporary community standards, would appear to the average person to appeal to the prurient interest; material that depicts sexual conduct in a patently offensive manner lacking "serious literary, artistic, political or scientific value," or "obscene or licentious material." **"Sexual contact"** means any act of sexual gratification involving: touching, directly or through clothing, the sex organs, buttocks, or anus of any person and the touching of a female's breast; encouraging the child to touch the offender in sexual manner; or requesting to touch the child in a sexual manner. In a specific complaint of child maltreatment, evidence of sexual gratification may be inferred from the attendant circumstances. However, "normal affectionate hugging" is not to be construed as sexual contact.

"Sexual exploitation" means allowing, permitting or encouraging participation or depiction of the child in prostitution, obscene photography or filming, or obscenely depicting, posing, or posturing the child for any use or purpose.

"Neglect" includes those acts or omissions by a parent, guardian, custodian, foster parent, or any person who is entrusted with the child's care, but excluding the spouse of a minor and the parents of a married minor, that constitute: (1) the failure or refusal to prevent the abuse of a child when the person knows or has reasonable cause to know the child is or has been abused; (2) the failure to provide the necessary food, clothing, shelter, and education required by law, (excluding failure to follow an individualized educational program); (3) the failure to provide medical treatment necessary to the child's well-being, except when the failure is caused by financial inability and no services for relief have been offered or rejected; (4) the failure to take reasonable action to protect the child from maltreatment, including from "parental unfitness," when the existence of the condition was known or should have been known; (5) the failure to provide for the necessary physical, mental, or emotional needs of the child "including failure to provide a shelter that does not pose a risk to the health or safety of the" child; (6) the failure to provide for the child's care and maintenance, proper or necessary support, or medical, surgical, or other necessary care;(7) the failure, although able, to assume responsibility for the care and custody of the child or to participate in a plan to assume such responsibility; and (8) the failure to properly supervise the child that results in the child being left alone at an inappropriate age or in inappropriate circumstances that create a dangerous situation or put the child at risk of harm. As discussed above, Garrett's Law expands the definition of "neglect" to include circumstances where a newborn has an illegal substance present or has a health problem resulting from the mother's use of an illegal substance before the child's birth.

Ark. Code Ann. § 12-18-103.

<u>Reports by Counselors or Therapists Naming an Adult as the Victim</u>

Under the 2009 revisions, certain counselors or therapists may report some offenses against adults to the Child Abuse Hotline. The new law permits the Hotline to accept a report of sexual abuse, sexual contact or sexual exploitation naming an adult as the victim if: (1) the alleged offender is a child's caretaker, and (2) the person making the report is either the adult victim, the alleged offender, law enforcement, or the "counselor or therapist" of either the adult victim or the alleged offender.

Ark. Code Ann. § 12-18-306.

Photographs and X-rays

Medical care providers may take photographs or x-rays, or compile medical records that show the existence or extent of child maltreatment. Both the Department of Human Services and law enforcement officials must be provided copies, a no cost, of the results of radiological procedures, videotapes, photographs or medical records on request. Hospitals and clinics may make videotapes relevant to the existence or extent of maltreatment
Ark. Code Ann. § 12-18-615.

DHS Authority and Medical Care

The 2009 law states that in certain cases, DHS "may pursue medical care or treatment" for a child when such care or treatment is necessary to prevent or remedy serious harm to the child or to prevent the withholding of medically indicated treatment for life-threatening conditions.
Ark. Code Ann. § 12-18-617.

Sexual Assault

Any medical facility that is licensed by the Department of Health and provides emergency services is required to follow the procedures listed below when treating a victim of sexual assault. A sexual assault includes rape, attempted rape, any other type of sexual assault, or incest.
Ark. Code Ann. § 12-12-403, as amended by Act 676 of 2007, and Act 758 of 2009.

Incest occurs when there is sexual intercourse or deviate sexual activity between persons who are sixteen years of age or older and are related as ascendants, descendants, stepchildren or step - grandchildren, adopted children or adopted grandchildren, siblings-either whole blood or half blood, uncles or aunts, or nieces or nephews. Incest also is defined as occurring if two persons, who are age sixteen or older and who are related as listed above, "purport to marry" each other.
Ark. Code Ann. § 5-26-202.

Emergency Medical-Legal Examination

An appropriate emergency medical-legal examination means health care with an emphasis on the collection of evidence for the purposes of prosecution. A medical-legal examination includes all components contained in an evidence collection kit for sexual assault examination as distributed by the Forensic Biology Section of the State Crime Laboratory. Physicians may obtain kits by writing or faxing a request specifying the number of kits desired to Arkansas State Crime Laboratory, Post Office Box 8500, Little Rock, Arkansas, 72215; Fax: (501) 227-0713; Telephone: (501) 227-5747.

The sexual assault victim may not be transferred to another facility unless the victim requests transfer, or a physician (or other qualified medical personnel when a physician is not available) has certified in writing that the benefits to the patient's health would outweigh the risks of transfer to the patient's health. In the case of a victim under the age of 18, either the victim or his or her parents must request the transfer. The transferring facility must forward the medical records and ensure that the appropriate transportation is available.

A medical facility that does not comply with these provisions is subject to having its license suspended or revoked.
Ark. Code Ann. §§ 12-12-401, 402, as amended by Act 758 of 2009.

Adult Victims

There are some special rules regarding reporting of sexual assaults: (1) the adult victim makes the decision as to whether to report the incident to a law enforcement agency; (2) medical treatment may not be made contingent on the victim reporting the incident to a law enforcement agency; (3) evidence may only be collected with the victim's permission, unless the victim is unconscious, mentally incapable of consent, or intoxicated; (4) if the victim consents to reporting the incident, the medical facility, the licensed health care provider, or victim's designee, must call the law enforcement agency; (5) if the victim arrives in the emergency room of a hospital, the victim must be given a medical screening examination by a qualified person pursuant to the Emergency Medical Treatment and Active Labor Act; (6) the facility or provider must conduct a medical-legal examination and treat any medical injuries in the standard manner; (7) the facility or provider must collect specimens for evidence; and (8) if a law enforcement agency has been contacted and the victim has given permission, then the evidence must be turned over to law enforcement officers when they assume responsibility for the investigation.

Victims Under the Age of 18

Victims under the age of 18 years are to be treated similarly to suspected victims of child abuse. This means that medical facilities must report the suspected sexual abuse to either the state Department of Human Services or to a law enforcement agency. A medical-legal examination must be performed, and specimens must be collected for evidence. Any injuries must be treated in the standard manner.

Ark. Code Ann. §§ 12-12-401 to 405, as amended by Act 676 of 2007, and Act 758 of 2009.

Cancer

Physicians and other health care providers are required to report most cases of cancer to the Department's Arkansas Central Cancer Registry (ACCR) within six months after the date of diagnosis, or of discharge or "after a cancer case is known, even if diagnosed elsewhere." *Arkansas Department of Health Rules and Regulations Pertaining to Arkansas Cancer Registry, Section IV. C. (Oct. 27, 1994), Ark. Code Ann. § 20-15-201 and following.*

Notification must be made of cases of in situ or invasive neoplasms of the human body, not including squamous cell and basal cell carcinoma of the skin. *Section III. B.* The report must include the following personal information about the patient: name, address, date of birth, place of birth, race and Spanish/Hispanic origin, sex, Social Security number, county of residence, marital status, maiden name and/or alias, if applicable; occupational history, if available, and tobacco use status, if available. The report also must include the following information about the diagnosis and treatment: class of case, date of diagnosis, primary site, laterality, histology, grade, diagnostic confirmation, staging, identification of the person or facility reporting, date the first course of treatment began and type(s) of treatment used, name of physician, follow-up and recurrence. *Section IV. A.*

The regulations state that Health Department staff shall have access to medical records, including those of physicians, to ensure the accuracy and completeness of the ACCR. *Section IV.B.* Under the regulations, all information reported to the Registry is confidential and is not to be disclosed except to: (1) other state cancer registries with which the Health Department has agreements to insure confidentiality, (2) other state health officials who are obligated to keep the information confidential, and (3) to approved cancer research centers where the names and identities of the individuals are appropriately protected and where research is conducted on cancer prevention, treatment and control. *Section V.* The statute on confidentiality states that

information in the Registry "shall not be divulged except as statistical information which does not identify individuals." *Ark. Code Ann. § 20-15-203*.

It is likely this state law is not preempted by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) because it falls within the public health activities exception of HIPAA, which would permit such disclosures.

Knife and Gunshot Wounds

All physicians, surgeons, hospitals, pharmacists, and other health care providers are required to report to local law enforcement all cases of knife or gunshot wounds treated by them that appear to be intentionally inflicted. Failure to do so may result in a fine from $10 to $100.

The report must be made immediately by telephone on learning the nature of the injury. If the report cannot be made by telephone, then it may be done by writing. The report must contain the name, age, sex, race, and location of the person injured, together with names of persons bringing the patient in for treatment.

Ark. Code Ann. §§ 12-12-601 to 603.

Sudden Infant Death Syndrome

Duty to Report

Any physician or hospital knowing of the sudden death of a child between the ages of one week and one year who was in apparent good health must report the death. The report must be made to the county coroner or county sheriff within 24 hours of the discovery of death. The report must "include facts concerning time, place, manner, and circumstances surrounding the death."

Permission to Perform Autopsy

The county coroner or county sheriff must request written permission for an autopsy from the infant's parents or guardian to determine the cause of death. The Department of Health will then arrange transportation to a physician who will perform the autopsy. The cause of death will be reported to the parents of the child. The term "sudden infant death syndrome" shall be recorded on the death certificate as the cause of death, if applicable. The Department of Health will pay for transportation and autopsies of suspected victims of sudden infant death syndrome so long as federal funds are available. If the parents refuse autopsy, the coroner must nevertheless report the death to the Department of Health.

Ark. Code Ann. §§ 20-15-502 to 504.

Reye's Syndrome

Physicians must report any case or suspected case of Reye's Syndrome disease to the Department of Health. The report should be made as quickly as possible following examination or prescription. The report needs to contain the name, age, sex, race, and residence of the patient. The nature of the disease, the date of onset, and other important information should also be furnished. The Department of Health then reports the information to the federal Centers for Disease Control.

Ark. Code Ann. § 20-15-401.

See also, AIDS at page 24; Family Planning, Abortion at page 93; Communicable Diseases at page 51; Rabies at page 215; Sexually Transmitted Disease at page 231; and Vital Statistics at page 242.

RURAL MEDICAL SERVICES

Financial Incentives

The State of Arkansas provides incentives for physicians and surgeons to establish their practices in rural areas. Rural areas are those cities, towns, and areas with a population of 15,000 or less. The Arkansas Department of Health and the University of Arkansas for Medical Sciences each are involved with incentive programs. All of the programs are dependent on the level of funding provided.

Student Loans and Grants

The Arkansas Rural Medical Practice Student Loan and Scholarship Program enables recipients to convert their medical school loans to scholarship grants by practicing full-time primary care medicine in a rural community. Medical students eligible for this loan must be bona fide residents of Arkansas, be in need of financial assistance to complete medical studies, and be enrolled in good standing or accepted for admission in the College of Medicine of the University of Arkansas for Medical Sciences (UAMS) leading to a degree of Doctor of Medicine. Recipients must participate in a "medically underserved" and rural practice curriculum. "Medically underserved" mean an area that has unmet needs for medical services, due to such factors as: the ratio of primary care physicians to the population; the infant mortality rate; the percentage of population with incomes below the federal poverty level as it existed on January 1, 2007; the percentage of residents 60 years of age and older; the percentage of physicians 60 years and older; accessibility within the area to primary care medicine, and other relevant criteria determined by the Arkansas Rural Medical Practice Student Loan and Scholarship Board.

"Primary Care" is defined as Family Medicine, Internal Medicine, Pediatrics, General Surgery, Obstetrics/Gynecology, Emergency Medicine, and as of 2009, Geriatrics.

The maximum loan amount is $16,500.00 per academic year. Students may apply for subsequent loans for each year of medical school. The loans are repaid by the recipient residing in and practicing full-time primary care medicine in a rural community. For each continuous whole calendar year of full-time medical practice, the Board will cancel, by converting to a scholarship grant, the full amount of one year's loan plus accrued interest. Loans made for subsequent years will be converted the same way – one year of service for each year of financial assistance until the loan obligation is repaid.

Loan recipients are allowed one year of medical internship and no more than four additional years of primary care residency training, which must include practice experience in a rural community and must be approved in advance by the Board.

With approval by the Board, a recipient may practice in more than one qualified rural community to meet the recipient's obligation to practice full time.

Loan recipients must sign a contract that legally binds them to these obligations. If a recipient breaches the contract, he remains obligated to repay the loans plus interest, which begins to accrue from the date each loan check was received. Repayment is due in full at the time it is determined by the Board that the recipient is not in compliance with the contract. For contracts entered into after August 1, 2007, a physician's Arkansas license to practice medicine may be suspended for breaching the contract only if the contract itself contained a provision stating that loss of license was a consequence of breach and the recipient acknowledged in

writing his awareness of this provision. The license suspension may be for a period of years equivalent to the number of years the recipient is obligated to practice medicine in a rural community and continue until the loan and interest are paid in full.

Interest shall not accrue and the obligation to repay the principal is suspended during any one period of time that the recipient involuntarily serves on active duty in the United States armed forces. If a recipient dies, the entire loan amount that has not been converted to a scholarship grant becomes due and payable.

To apply, call or write: Morgan Hogue, Administrator, Rural Practice Programs, 4301 West Markham Street, #709-1, Little Rock, AR 72205, (501-526-4266).

Financial Incentives for New Physicians

The Arkansas Community Match and Rural Physician Recruitment Program also is administered by the Arkansas Rural Medical Practice Student Loan and Scholarship Board. The objective of this program is to increase the number of primary care physicians in rural Arkansas by providing financial incentives to physicians who are either: (1) currently enrolled in a residency or other training program in an area of primary care or in a designated specialty approved by the Board or (2) who completed such training no more than two years prior to their application for this program. A physician and a "qualified rural community," *i.e.* one that is "medically underserved" as previously defined, must jointly apply for the program. Participants make a four-year commitment to practice full-time medicine in their match community, and they must sign a legally binding contract. The maximum amount a physician may receive is $80,000.00 over the four years. The physician is sent no more than $5,000.00 at the end of every three-month period of service. The income from this incentive program is taxable income. If a physician fails to begin practice or ceases to practice in breach of his contract, the physician may be liable to pay civil money penalties of up to 50 percent of the principal amount. In addition, the physician must repay any unearned money received, with interest, and he must pay any actual costs incurred by the community in reliance on the physician's promise to practice there. Failure to engage in medical practice in accordance with the contract may result in suspension of the physician's Arkansas license to practice medicine for a time period equal to the number of years the physician was obligated to practice medicine in a rural community and/or until the funds, with interest, are repaid in full.

To apply, call or write: Morgan Hogue, Administrator, Rural Practice Programs, 4301 West Markham Street, #709-1, Little Rock, AR 72205, (501-526-4266).

Financial Incentives for All Physicians

Arkansas-licensed physicians are eligible for financial assistance if they locate a primary care practice, after July 1, 1999, in a qualified rural community and remain there for at least four continuous years.

Those physicians who qualify may receive grants totaling $55,000.00 paid over four years. The first payment of $25,000 is made when the physician establishes a practice in the community and patients are being seen in the office. The second, third and fourth payments of $10,000 each will be made after completion of each continuous year of service.

Grant recipients must enter into a contract to serve a proportionate number of Medicaid patients for the community, agree to work within the existing health care system and practice a minimum of thirty-two hours a week.

With only some limited exemptions, a grant recipient who does not engage in the practice of primary care consistent with the terms of his agreement must repay the grant with interest. The entire amount is due when it is determined that the agreement has been breached.

For more information physicians may call or write: Bill Stricklin, Arkansas Department of Health, Office of Rural Health and Primary Care, 4815 West Markham Street, Slot 22, Little Rock, Arkansas, 72205, (501) 280-4560.

Ark. Code Ann. § 6-81-701 and following, as amended by Act 1058 of 2007, Act 708 of 2009; Ark. Code Ann. §§ 20-12-501 and 20-12-503.

Rural Medical Clinic Revolving Loan Fund

A "Rural Medical Clinic Revolving Loan Fund" exists through the Arkansas Department of Health to provide money for loans to certain medical practitioners to construct and equip rural medical clinics.

A practitioner or rural medical clinic may receive up to an aggregate sum of $150,000 in loan money. The annual interest rate is 5% for a period of ten years or less. Loans are secured by a first lien mortgage on the lands, buildings, and equipment acquired with the loan. The entire unpaid balance of the loan and unpaid interest becomes due in cases of delinquent payment or use of the property as other than a medical clinic.

Before the issuing of a loan, the Board of Finance must determine that the rural area does not possess adequate medical services, and that the land, building, and equipment to be acquired is needed to meet the needs of the rural community. The medical practitioner(s) seeking the loan must enter into an agreement with the board to "practice in the rural medical clinic for the period in which the loan is applied."

Further, the Department of Health issues rules and regulations of applicant eligibility. These other requirements include:

1. A person with an already established practice will not be considered an eligible applicant except under extreme circumstances threatening the continuance of his service to the rural community;
2. The applicant must serve a proportionate amount of Medicaid patients for the rural community;
3. The applicant must demonstrate a willingness to work within the existing health care system;
4. The applicant must practice a minimum of 32 hours a week; and
5. No applicant with professional income guarantees from other sources shall be approved under this program.

Ark. Code Ann. § 20-12-201 and following.

To apply for this loan, physicians may call or write: Bill Stricklin, Arkansas Department of Health, Office of Rural Health and Primary Care, 4815 West Markham Street, Slot 22, Little Rock, Arkansas, 72205, (501) 280-4560.

Rural Health Services Revolving Fund - Matching Grant

Health providers may also apply to the Department of Health for a "matching grant" of up to $200,000. Applicants must match the requested grant on a 50/50 cash basis. Applicants who have completed a community health needs assessment are eligible to match the requested grant on a 25/75 cash basis. This is a one-time grant that may be used in a primary care or emergency medical service facility.

To apply for this grant, physicians may call or write: Bill Stricklin, Arkansas Department of Health, Office of Rural Health and Primary Care, Rural Health Services Matching Grant, 4815 West Markham Street, Slot 22, Little Rock Arkansas, 72205, (501) 280-4560.
Ark. Code Ann. § 20-12-404.

Medical School Admissions

In 2003, the General Assembly added an additional factor to be considered in deciding admissions to the University of Arkansas College of Medicine. The U.A. Board of Trustees "shall give additional consideration to rural applicants from medically underserved areas in an effort to address health disparities." The U.A. Board was tasked with issuing rules and providing resources for area health education centers to offer programs to prepare identified medical school candidates from medically underserved areas for the Medical College Admission Test. *Ark. Code Ann. § 6-64-406, as amended by Act 836 of 2007.*
An alternate moves to the top of the medical school admission waiting list if the alternate enters into a rural medical practice loan contract to practice primary care in a rural community, and his or her application is approved by the Arkansas Rural Medical Practice Student Loan and Scholarship Board. The priority on the waiting list for those alternates is determined by the date and time such alternate enters into the rural practice medical loan contract. However, the college must still meet the statutory requirements for allocation of enrollment positions for medical students among congressional districts before admitting an alternate who has entered into a rural practice loan contract. *Ark. Code Ann. § 6-81-708, 6-81718, as amended by Act 1058 of 2007, and Act 376 of 2009.*

SALES TAX EXEMPTIONS

Prescription Drugs

Prescription drugs including oxygen and insulin and test strips are not subject to the Arkansas sales tax or the Arkansas compensating use tax.
Ark. Code Ann. § 26-52-406(a); §26-52-419; §26-52-433

Other Medical Items

Also exempt from sales and use taxes are the following, as long as they are prescribed by a physician: durable medical equipment, mobility-enhancing equipment, prosthetic devices and disposable medical supplies. Additionally, sales of insulin and blood sugar testing strips are exempt.
Ark. Code Ann. § 26-52-419; § 26-52-433.

Out-of-State Purchases

Out-of-state purchases (other than prescription drugs or other exempt purchases) in which a sales tax was not charged by the originating state are subject to assessment of a "use tax" in Arkansas if the purchases are used in Arkansas. A use tax is equivalent to a sales tax.
Ark. Code Ann. § 26-53-101 and following, as amended by Acts 110 and 181 of 2007, and Acts 384, 655, & 1208 of 2009.

SEAT BELT USE BY THOSE IN WHEELCHAIRS

Each person seated in a wheelchair in a motor vehicle must wear a seat belt secured to the wheelchair and the wheelchair must be "properly secured" in the motor vehicle. Seat belt use is not required if the person has a physical disability which contraindicates the use of a seat belt and the condition is certified by a physician who states the nature of the disability and the reason the use of a seat belt is inappropriate.
Ark. Code Ann. § 27-37-702.

SERVICE BY RETIRED PHYSICIANS

Retired physicians who are still licensed to practice medicine possess immunity from liability for any civil damage arising out of medical treatment voluntarily provided to patients without compensation. The treatment must be rendered at a free or low-cost medical clinic which does not accept insurance payments. Retired physicians remain liable for any gross negligence or willful misconduct. This section has been extended to cover *any* physician or health care professional who renders such service.
Ark. Code Ann. §§ ; 16-6-201, as amended by Act 837 of 2007; 17-95-106.

See also, Tort Liability - Immunity, Indigent Care at page 240.

SEXUALLY TRANSMITTED DISEASES (STD)

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) changed some of the requirements on handling information on STDs, most significantly in situations involving minors. Physicians still have a duty to report STDs to the state Health Department. The HIPAA Privacy Standards do permit certain disclosures required by state law or that are necessary for public health purposes.

Duty to Report

Physicians and laboratories must notify the Department of Health, within 24 hours, of any laboratory examination revealing evidence of STD. The physician's duty exists even if a separate laboratory reports the STD. The following conditions must be reported if found: (1) syphilis, (2) gonorrhea, (3) chancroid, (4) lymphogranuloma venereum, and (5) granuloma inguinale.

Certain test results must be reported. These include the following:

1. all reactive or positive and weakly reactive or doubtful serological tests for syphilis;
2. all reactive or positive and weakly reactive or doubtful spinal fluid serological tests for syphilis;
3. all positive darkfield microscopic tests for treponema pallidum;
4. all positive gonococcal smears or cultures; and

5. all positive tests indicating the presence of the Ducrey's bacillus, known as chancroid, or Donovan bodies, known as granuloma inguinale, or filterable virus, known as lymphogranuloma venereum.

Contents of Notification

Notification must either be made on the Confidential Case Report form provided by the Department of Health or made by telephone to the department's answering service at (800) 482-8888. The following information is required to be reported: (1) test results by type, date, number of specimens testing negative, and number of specimens giving a positive or "doubtful result;" (2) name, age, sex, and address of persons having either a positive or doubtful test result; and (3) name and address of the physician ordering the tests.

Further, reports of primary, secondary, or congenital syphilis in a newborn must be made within 24 hours of birth. A diagnosis of syphilis in a pregnant woman must be reported within 24 hours of the diagnosis. Reports of both newborn syphilis and syphilis in pregnant women must include the name, address, age, sex, race, and date of birth.

Confidentiality

All notification reports remain confidential. Only public health personnel may open or inspect the reports.

Duty to Inform and to Treat the Patient

Physicians must counsel patients infected by a sexually transmitted disease on the first visitation. The physician should provide information on precautionary measures necessary to prevent spread of the disease and explain the necessity of uninterrupted treatment. Physicians must administer adequate treatment to patients whom they believe are infected or have been exposed to a sexually transmitted disease regardless of age, sex, disability, or race. Pregnant women must be told that syphilis, HIV and hepatitis B may be transmitted from the infected mother to the fetus or unborn child and that this infection may be prevented if the maternal infection is recognized and treated.

Penalties

Any physician failing to make a required notification to the Health Department commits a violation that is punishable upon conviction by a fine of $10 to $25.

See also, AIDS at page 24 and Communicable Diseases at page 51.

Duty to Test During Pregnancy

Any physician caring for a pregnant woman must test for syphilis, HIV, and Hepatitis B. Only a woman's refusal to be tested relieves the physician of the responsibility to have the tests performed, and the refusal must be documented in the patient's record. However, there is a conflict between this law and another, the "HIV Shield Law," which states that informed consent for an HIV test is not required in certain circumstances, as long as the patient has otherwise consented to treatment. ***See Acquired Immune Deficiency Syndrome, HIV Shield Law at page 25, and Pregnant Women Testing at page 25.***

For the syphilis, HIV, and Hepatitis B tests, a venous blood sample should be taken at the first examination and then submitted to a CLIA-approved laboratory for serological testing.

A physician reporting a birth or stillbirth must state on the certificate whether a blood test for

syphilis was taken from the mother. The statement must include the date the specimen was taken.

Consent of Minors

If a minor believes he has contracted a sexually transmitted disease, his consent for medical treatment will be valid even though he has not reached the age of majority. This applies to consent given to physicians, hospitals, and clinics providing medical care. Thus, consent of a spouse, parent, or guardian is unnecessary in such situations. The minor cannot later claim that his consent was invalid by reason of minority.

While Arkansas law provides that a physician or member of the medical staff may, but is not obligated to, inform a parent, or guardian of treatment given to a minor and that such information may be given or withheld "without the consent and over the express objection of the minor", this portion of the Arkansas law may be pre-empted by HIPAA. Before making any disclosure in reliance on state law, physicians should consult with legal counsel. Under the HIPAA Privacy Standards, unauthorized disclosure of the condition or medical treatment of a minor to a parent, spouse or guardian is prohibited in certain circumstances, such as when a minor may under state law obtain medical treatment without parental consent, as is the case in Arkansas.

Also, it is likely that the portion of the Arkansas law allowing unauthorized disclosure to a minor's spouse generally is pre-empted by HIPAA, but disclosure might be allowed if the minor were of unsound mind or if the spouse were the guardian of the minor. Practitioners should consult legal counsel before making any unauthorized disclosures.

Ark. Code Ann. § 20-16-501 to 508, as amended by Act 194 of 2005, as amended by Act 827 of 2007, and Act 952 of 2009; Ark. Code Ann. § 20-15-905; Ark. State Bd. of Health Regulationd (Rev. August 11, 2009).

See also, Communicable Diseases at page 51; Malpractice, Mature Minor Doctrine at page 158.

SMOKING

Prohibition of Tobacco Smoking

Smoking is prohibited in and on the grounds of Arkansas medical facilities, with the exception of psychiatric hospitals, or in cases where a physician enters an order permitting an in-patient to smoke.

The banned tobacco use means smoking of cigars, cigarettes, pipes or use of any other tobacco-smoking devices. "Medical facilities" means hospitals, including both inpatient and out-patient services; hospital-owned and operated ambulatory surgery centers; and hospital-owned and operated free-standing medical clinics. However, "medical facilities" does not include psychiatric hospitals as defined by the Department of Health. A medical facility's "grounds" are the buildings in and on which the facility operates, including all property owned by the facility that is contiguous to the buildings in which medical services are required.

Medical facilities must ask any person in violation of this law to stop. If an offender continues to smoke, the facility may report the violation to the appropriate law enforcement agency. Facilities are required under the law to post signs in English and in Spanish explaining the prohibition of smoking.

Exception

Upon determination that an in-patient's treatment will be "substantially impaired" by denying that patient tobacco use, the treating physician may enter a written order permitting the use of tobacco by that patient. The physician's order must be consistent with the medical facility's medical staff bylaws, hospital regulations, and local ordinances.
Ark. Code Ann. § 20-27-705 to -709.

STERILIZATION

Physicians may perform permanent sterilization upon request by persons 18 years or older if they consent. Physicians may also sterilize those consenting persons under 18 years of age who are legally married. No physician becomes civilly or criminally liable for having performed surgical sterilization absent evidence of negligence.

Physicians and private institutions, or their agents and employees, may refuse to furnish contraceptive procedures, supplies, or information based on religious or conscientious objection. Those refusing to furnish cannot be held liable for their refusal.
Ark. Code Ann. § 20-16-304 to 305.

Mental Incompetents

The guardian of an adult alleged to be "incompetent", or the parent or guardian of a minor alleged to be incompetent, may petition the circuit court for sterilization of the incompetent person. An "incompetent" is defined as one incapable of caring for himself or herself because of a mental incapacity that will not improve and whose sexual inclinations make it probable that he or she will procreate.

Certain aspects of the state statutes setting out the procedure for sterilization of incompetents likely are pre-empted by the federal Health Insurance Portability and Accountability Act (HIPAA). State law appears to run afoul of HIPAA by, among other things, not providing for a protective order. Practitioners should consult legal counsel before following the procedures set out in state law.

See HIPAA at page 115.

Determining Incompetency

Under state law, the circuit court requires that at least two medical witnesses testify to the incompetency of a person. One of these witnesses may do so by written statement. If the alleged incompetent is confined or undergoing treatment for mental or nervous disease at a hospital or institution, one of the witnesses must be a member of the medical staff of the hospital or institution.

The circuit court may further appoint medical examiners to examine the alleged incompetent and report their findings. The court fixes the fees paid to any appointed medical examiners.

Method of Sterilization

The circuit court may order sterilization of the incompetent by x-ray or vasectomy for males

or by salpingectomy for females. Other procedures generally accepted by the medical profession may also be ordered by the court.

Nonliability of Physician/Hospital

Physicians and hospitals performing court-ordered sterilizations are protected from liability as long as they observe the appropriate standard of care.
Ark. Code Ann. §§ 20-49-101, 201 to 207.

SUBPOENAS

A witness may be subpoenaed for examination at a trial, hearing, or deposition. The subpoena must state the name of the court, the title of the action, and the time and place at which the witness should appear.

A deposition may be taken by oral examination or with written questions, though the latter method is rarely used. A deposition reaches any information relevant to the pending action that is not privileged information.

Appearance in State Court

County sheriffs, their deputies, or court-appointed persons at least 18 years of age and not a party to the suit must deliver a copy of the subpoena to the witness. This constitutes "service." Also, attorneys may serve subpoenas by return-receipt-requested mail with delivery restricted to the addressee.

Service may occur by telephone when the trial or hearing is to be held in the county of residence of the witness. Service by telephone may only be made by the county sheriff or a deputy.

Subpoena of Witness for Trial or Hearing

A witness served with a subpoena must appear at a civil trial or hearing regardless of the location within the state. The subpoena must be served at least two days prior to the trial or hearing.

A witness fee must accompany the subpoena. Witness fees are calculated at $30 per day plus $0.25 per mile of travel.

Persons subpoenaed must remain in attendance until excused. The court may excuse the witness after his testimony or the party summoning the witness may excuse the witness before any testimony is given.

Subpoena of Witness for Deposition

Witnesses subpoenaed for deposition must be given at least five business days' notice. The subpoena must be accompanied by a witness fee of $30 per day plus $0.25 per mile.

Witnesses subpoenaed for deposition are required to appear at any place designated which is within 100 miles of their place of residence, employment, or business. Parties to an out-of-state proceeding may take the deposition of witnesses within Arkansas.

Protective Orders

Courts may protect witnesses from annoyance, embarrassment, or undue burden or expense by issuing "protective orders." The witness or a party must file a motion seeking the protective

order. Only the court where the action is pending may issue a protective order.

Expert Witnesses

Many times, a party to a lawsuit will employ a physician as an expert witness. Sometimes the parties will require the physician to submit to a discovery deposition in which the opposing party asks the physician oral questions under oath to find out about his or her expected testimony. Subsequently, the physician will be called to testify. Sometimes the parties will skip the discovery deposition and proceed directly to the physician's testimony. This testimony may be given in the traditional manner in open court through direct and cross-examination. Alternatively, it may be provided through an "evidentiary deposition" that is taken outside of court at the physician's convenience, is usually videotaped, and is conducted through direct and cross-examination just as if in court. The transcript or videotape is then introduced into court instead of requiring the physician to appear.

Technically, the Rules of Civil Procedure do not require that an expert be paid more than the standard $30 witness fee for time spent in court, but the usual practice in Arkansas is for the party hiring the expert to pay a reasonable fee in line with the value of professional time. However, if the opposing party conducts a deposition or any other discovery before trial, the Rules require that the discovering party pay the physician a reasonable fee.

When the mental or physical condition of a person is in issue in a court case, the court may order the person to submit to an examination by a physician. The party requesting the examination typically pays the medical charges. When requested, the physician must provide a detailed written report of the examination which sets out the results of tests, diagnoses, and conclusions. The report should also include the findings of earlier examinations made concerning the same condition.

Contempt of Court

Witnesses failing to appear as ordered by subpoena, and witnesses evading service of a subpoena may be held in contempt of court. The court may issue an arrest warrant compelling the witness to appear before the court, "give testimony, and answer for contempt."
Arkansas Rules of Civil Procedure 26, 35, 45.

Appearance in Federal Court

A subpoena for appearance in federal court or deposition for a case in federal court may be served by any person over 18 years of age who is not a party to the case. The subpoena must be delivered to the witness along with a $40 per day witness fee and mileage as allowed by law. . Fees need not be tendered when the subpoena issues from the United States, or from one of its officers or agencies.

Subpoenas for appearance in federal court may be served at any place within the federal district or any other place within 100 miles of the deposition, hearing, or trial.

Protection from Undue Burden

Parties to a lawsuit or their attorneys may not force a witness to suffer an undue burden or expense in testifying. The court may award lost earnings, reasonable attorney's fees, or other costs to witnesses who suffer an undue burden or expense.

Protective Orders

Courts may issue protective orders to protect witnesses from annoyance, embarrassment,

oppression, or undue burden or expense. The witness or a party must file a motion seeking the protective order. A significant difference exists between the federal and state rules. The federal rules allow either the court where the deposition is taken or the court where the action is pending to issue a protective order.

Modification of Subpoena

The court may modify or revoke a subpoena upon the filing of a motion by the witness or a party. Legitimate reasons for asking for modification or revocation include when the subpoena: (1) "fails to allow reasonable time for compliance; (2) requires a person who is not a party . . . to travel to a place more than 100 miles from the place where that person resides, is employed or regularly transacts business in person" with some exceptions; (3) requires disclosure of privileged or other protected matter and no exception or waiver applies; or (4) subjects a person to undue burden." If the witness lives in the same state as where the trial is being held, a court may compel a witness to travel more than 100 miles to attend the trial.

The court may also modify or revoke a subpoena if it requires disclosure of trade secrets, confidential research, development or commercial information; requires disclosure of an unretained expert's opinion or information gathered by the expert not based on the specific events at issue in the lawsuit; or requires a person, who is not a party, to incur "substantial expense" in traveling more than 100 miles to attend the trial. The court may, however, order the witness to appear in these situations if the testimony cannot be obtained otherwise without undue hardship on the party subpoenaing the witness. When the court orders such an appearance, the party seeking the testimony must reasonably compensate the witness.

Contempt

Contempt of court occurs when a person subpoenaed fails to appear without adequate cause. Adequate cause not to appear exists when the subpoena requires a non-party witness to travel more than 100 miles from his place of residence or business. The best practice is to contact your attorney to discuss how to proceed if you do not believe you are required to appear.

Expert Witnesses

Many times, a party to a lawsuit will employ a physician as an expert witness. Sometimes the parties will require the physician to submit to a discovery deposition in which the opposing party asks the physician oral questions under oath to find out about his or her expected testimony. Subsequently, the physician will be called to testify. Sometimes the parties will skip the discovery deposition and proceed directly to the physician's testimony. This testimony may be given in the traditional manner in open court through direct and cross-examination. Alternatively, it may be provided through an "evidentiary deposition" that is taken outside of court at the physician's convenience, is usually videotaped, and is conducted through direct and cross-examination just as if in court. The transcript or videotape is then introduced into court instead of requiring the physician to appear.

Federal rules require experts to prepare written reports that will be provided to the other side in the lawsuit. The report must contain: (1) "a complete statement of all opinions the witness will express and the basis and reasons for them"; (2) the data or information considered by the expert in forming the opinions; (3) any exhibits to be used to summarize or support the opinions; (4) the qualifications of the expert, including a list of all publications authored by the expert within the last ten years; (5) the compensation to be paid the expert; (6) and a listing of any other cases in which the expert has testified as an expert at trial or by deposition within the preceding

four years.

Technically, the Rules of Civil Procedure do not require that an expert be paid more than the standard $40 witness fee for time spent in court, but the usual practice in Arkansas is for the party hiring the expert to pay a reasonable fee in line with the value of professional time. However, if the opposing party conducts a deposition or any other discovery before trial, the Rules require that the discovering party pay the physician a reasonable fee.

When the mental or physical condition of a person is in issue in a court case, the court may order the person to submit to an examination by a physician. The party requesting the examination typically pays the medical charges. When requested, the physician must provide a detailed written report of the examination which sets out the results of tests, diagnoses, and conclusions. The report should also include the findings of earlier examinations made concerning the same condition.

Federal Rules of Civil Procedure 26, 35, 45; 28 U.S.C. § 1821(b).

Subpoenaed Documents and Electronic Discovery

In either federal or state court, a subpoena may require a witness or a party to the litigation to personally appear and/or produce documents or electronically stored records. Court rules can impose requirements to preserve electronic files. Physicians who receive such a subpoena should contact legal counsel to determine what obligations may be imposed and whether any objections should be made to the subpoena.

Federal Rule of Civil Procedure 34; Arkansas Rule of Civil Procedure 26.1

SUDDEN INFANT DEATH SYNDROME

See Death, Dying and Disposition of the Dead, "Unexpected" Death of a Child at page 62; Reporting, Mandatory Physician at page 216.

TELEMEDICINE

Telemedicine, also known as e-health or telehealth, is becoming a growing area of concern among health care practitioners. Telemedicine is defined generally as the use of medical information exchanged from one site to another via electronic communications to improve patients' health status. Telehealth is often used to encompass a broader definition of remote healthcare that does not always involve clinical services.
American Telemedicine Association; ATA Defining Telemedicine; http://www.americantelemed.org/i4a/pages/index.cfm?pageid=3333.

For the purposes of Medicaid, telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's health. Telemedicine is viewed by CMS as a cost-effective alternative to the more traditional face-to-face way of providing medical care that states may choose to cover. This definition is modeled on Medicare's definition of telehealth services, but federal Medicaid regulations and laws do not recognize telemedicine as a distinct service. Arkansas Medicaid both recognizes telemedicine services and reimburses for those services in certain areas. *Center for Medicare & Medicaid Services, Overview Telemedicine, http://www.cms.hhs.gov/Telemedicine/. CMS Medicare Pub. 100-2, §15.270 and following (August 07, 2009); Arkansas Medicaid Provider Manual §226.200 and following.*

According to the AMA, providing care through telemedicine consultation is becoming more prevalent in facilities. Under AMA Joint Commission MS.4.130, the medical staff is to make recommendations as to which services are appropriately provided via telemedicine. Joint Commission Standard MS.4.120 requires the credentialing of the distant provider by the medical staff of the health care entity caring for the patient, subject to that hospital's medical staff credentialing and privileging process. Arkansas state law requires licensure of the distant provider with the Arkansas State Medical Board. *AMA - Physician's Guide to Medical Staff Organization Bylaws, 4th (2007). Ark. Code Ann. §17-95-206.*

See also Prescriptions, Internet and Electronic Mail at 211 and Telemedicine at 212; Electronic, Facsimile and Oral Prescriptions at 72; Electronic Prescriptions for Controlled Substances at 74.

TORT LIABILITY – IMMUNITY

Board Members

Members of a board of the healing arts, such as the State Medical Board, possess immunity from liability "to any person for slander, libel, defamation of character, breach of privileged communication," or other actions taken within the scope of the board's functions. The actions taken must be without malice and warranted by the facts as the board member knows them.
Ark. Code Ann. § 17-80-103.

Hospital Utilization Review Committees

Physicians appointed to hospital utilization review committees possess immunity for any decisions made in that role as long as they act in good faith.
Ark. Code Ann. § 20-9-304, 502, 702; 20-46-102.

See also Peer Review Committees at page 196; Credentialing Organizations at page 55.

Indigent Care

As long as certain requirements are met, any physician or other health care professional who voluntarily provides free health care services at a free or low-cost clinic is immune from liability for damages for any act or omission in rendering the health care services, unless the professional was grossly negligent or engaged in willful misconduct. The clinic must be located in Arkansas, registered with the State Board of Health, not accept any insurance payments, provide health care free of charge to persons unable to pay or provide health care for a nominal fee, and use required forms to inform patients about the immunity from damages. Medical school students and residents can be covered by this immunity if they are providing services within the scope of their training and are supervised by a licensed physician.
Ark. Code Ann. § 16-6-201.

Records Provided for Study

Prior to the effective date of the federal Health Insurance Portability and Accountability Act (HIPAA), state law provided protection for certain unauthorized disclosures of Protected Health Information (PHI). However, it is likely that Ark. Code Ann. § 20-9-304, which provided this protection, is preempted by the more stringent federal law. Ark. Code Ann. § 20-9-304 permits authorized persons and hospitals to provide information, reports, and other data relating to the "treatment of any person" for use in studies to reduce morbidity or mortality to: (1) the State Board of Health, (2) the Arkansas Medical Society or any of its committees or allied societies, (3) any national organization approved by the State Board of Health, and (4) any in-staff committee of licensed hospitals. It states that no liability may be enforced for the release of information or for the publication of findings, summaries, or conclusions of any studies. It provides that the identity of persons whose information is studied must remain confidential at all times, and that any provided information should not contain the names of any persons and should not violate patient/physician confidentiality. However, Ark. Code Ann. § 20-9-304 does not set out any standards to be followed in de-identifying PHI, and therefore runs afoul of HIPAA Privacy Standards, which contain detailed requirements on how PHI should be de-identified. Additionally, the statute does not mandate that the information be collected, and the entities permitted to receive the information are not limited to public health authorities. Nevertheless, public health authorities, as defined by federal law, should be able to collect this information under the public health activities exception to HIPAA, as long as HIPAA's requirements are met. Legal counsel should be consulted before any information is disclosed or collected in reliance on this state statute.
See HIPAA at page 115.

Treatment of the Mentally Ill

Physicians possess immunity from liability for actions pursuant to the laws on voluntary and involuntary commitment unless they act with bad faith, malice, or gross negligence.
Ark. Code Ann. § 20-47-227.

See also, AIDS at page 24; Organ Donation at page 193; Emergency Medical Care at page 78; Credentialing Organizations at page 55; Governmental Tort Immunity at

page 115; Physician Assistants at page 203; Peer Review Committees at page 196; and Sterilization of Mental Incompetents at page 234.

TUBERCULOSIS

Under state law, state, county, or city health officials may apprehend and detain persons whom they believe are infected by communicable tuberculosis and will not voluntarily seek medical treatment. Health officials test for tuberculosis and determine if quarantine is needed. Legal counsel should be consulted in the rare event that action is to be taken under this law or under other state statutes on tuberculosis because . The federal Health Insurance Portability and Accountability Act (HIPAA) which sets out requirements before private health information can be released publicly, may pre-empt state law. ***See HIPAA at page 115.*** For example, in certain circumstances involving a person with active tuberculosis, state law requires the county health officer to petition the local court for an order to confine the person in a state hospital, and the law requires a hearing on the petition in open court. The state law also requires the director of a facility where a person has been treated for tuberculosis to report a patient's discharge from the facility to the state Health Department, the county health officer of the county where the person was committed and to the clerk of the court from which the person was committed. HIPAA requires court orders for certain disclosures of information about a person's health, and these state laws do not require court orders for disclosure, and therefore may be pre-empted by HIPAA.
Ark. Code Ann. §§ 20-15-703 to 709.

2009 Regulations

In 2009 the Arkansas Department of Health promulgated new regulations on controlling tuberculosis that changed the reporting requirements for physicians and that set out requirements for various facilities where people congregate. *See Communicable Diseases at Page 51 for the new reporting requirements.* Under the 2009 regulations, any physician or health care worker at a "related medical facility" who has contact with patients or clients must receive tuberculosis screening and prevention. "Related Medical Facility" means a facility other than a general medical-surgical hospital, such as a rehabilitation hospital, psychiatric hospital, substance abuse in-patient center, hospice, renal dialysis unit, community health center, Human Development Center, Arkansas State Veteran's Home, Veteran's Hospital Domiciliary, home health agency or community health clinic serving populations with a high prevalence of tuberculosis. For those who have not tested positive in the past, tuberculosis screening is defined as an intra-dermal skin test, with annual skin tests thereafter. For those who have tested positive in the past or who have a current positive test, a chest radiograph should be performed if one has not been done within the past three months. Other screening may be directed or recommended by the Health Department,

Prior to employment and each year thereafter, a physician and other health care workers who have patient or client contact must obtain a certificate of health or documented results of tuberculosis screening.

Ark. Dept. of Health Rules Pertaining to: The Control of Communicable Diseases – Tuberculosis 2009.

VISION TESTING, MANDATORY

Public and charter schools are required to provide specific eye and vision screening tests for all children in pre-kindergarten, kindergarten, and grades one, two, four, six and eight. Any child who fails the tests shall be required to have a comprehensive eye and vision examination by an optometrist or ophthalmologist within sixty days of receiving a report from the school of the failure.
Ark. Code Ann. § 6-18-1501 and following.

VITAL STATISTICS

The Department of Health acts as a "state health data clearing house" acquiring and disseminating information for patients, physicians, hospitals, and other health professionals. The Division of Vital Records operates the system of vital statistics throughout the state.

"Vital statistics" include data derived from reports of birth, death, fetal death, abortion, marriage, divorce, and annulment. "Vital records" means certificates of birth, death, marriage, divorce, and annulment, while fetal death and abortion reports constitute "vital reports."

Questions may be directed to the Division of Vital Records, Arkansas Department of Health, Division of Vital Records, 4815 W. Markham Street, Slot 44, Little Rock, Arkansas, 72205, (501) 661-2174 or (501) 661-2726.
Ark. Code Ann. § 20-7-302; §§ 20-18-102, 201.

Hospitals' Duty to Provide Data

State health care organizations, hospitals and outpatient centers must submit information to the State Board of Health as per its regulations, unless the same information is being collected by another state agency. In that case, the Department of Health will obtain information from the other agency.

Limited Discovery

Information that identifies a patient, provider, institution, or health plan shall be kept confidential and shall not be subject to discovery or the Freedom of Information Act.

Vital Records

Persons Required to Keep Records

Public and private institutions providing inpatient or outpatient medical care, nursing, custodial care, or domiciliary care must keep a record of personal data for each admitted patient. Further, a record must be made when a dead body is released or disposed of by an institution.

When

Records should be made at the time of admission. The institution obtains the information from the person being admitted. If the information cannot be obtained from the person admitted, it may be taken from relatives or other persons acquainted with the facts. *Ark. Code Ann. § 20-18-302.*

Contents

Certificates, records, and reports prepared by compiling institutions must include the minimum items as recommended by "the federal agency responsible for national vital statistics "and must be in the format approved by the state registrar in the Division of Vital Records of the Arkansas Department of Health. All vital records must contain the date of filing..

The information required for such records may be filed in "photographic, electronic, or other means prescribed by the state registrar."

Release of a Dead Body: When an institution releases or disposes of a dead body, the record must include the following: If removed, the record includes "the name of the decedent, date of death, name and address of the person to whom the body or fetus is released, and date of removal from the institution." If disposed of by the institution, the record must include "the date, place, and manner of disposition."
Ark. Code Ann. §§ 20-18-301 to 302.

Retention of Records

All records must be kept on file by the institution compiling the records for at least one year. The state registrar may inspect the records on demand.
Ark. Code Ann. § 20-18-302.

Penalties

Two degrees of punishment exist for violating the provisions essential to the Department of Vital Records' maintenance of certificates, records, and reports.

1. The first type of penalty results in punishment by a fine not exceeding $10,000, or imprisonment not exceeding five years, or both. The persons subject to the first type of penalty are those (a) who provide false statements or information when filing, amending, requesting a certified copy of, or preparing a record; (b) who without authority make, counterfeit, alter, amend, or mutilate a record, or a certified copy in an attempt to deceive; (c) who obtain, possess, use, sell, or furnish a deceptive record or certified copy; or (d) who possess stolen or unlawfully obtained records.
2. The second type of penalty results in punishment by a fine not exceeding $1,000, or imprisonment not exceeding one year, or both. The persons subject to the second type of penalty are those (a) who refuse to provide information as required; (b) who transport or accept for transportation a dead body not accompanied by a permit; or (c) who neglect, violate, or refuse to perform their duties under the law and regulations on vital statistics.

Ark. Code Ann. § 20-18-105, as amended by Act 827 of 2007.

Duty to Furnish Information

Persons with knowledge of any birth, death, fetal death, or abortion must furnish such knowledge on demand by the state registrar.

Births and Deaths

Each institution must furnish a list of all births and deaths occurring in the preceding

month to The Division of Vital Records. This list must be sent no later than the tenth day of the month.

Limited Liability

Persons or institutions furnishing information in good faith receive immunity from any suit for damages based on the furnishing of the information.
Ark. Code Ann. § 20-18-303.

Prohibition on the Disclosure of Information

Unless authorized by the State Board of Health, or by law, regulation, or court order, vital records shall not be disclosed for inspection or copying. Courts interpret this prohibition on disclosure as encompassing reports of aborted pregnancies. The board may authorize regulations allowing disclosure of vital records for research purposes. At all times, a physician may release information or data which does not identify a person or institution named in a vital record.
Ark. Code Ann. § 20-18-304.

Appeal of Custodial Decisions

Appeals of decisions made by a custodian of vital records must be made to the state registrar. The state registrar must make a decision within three working days. The decision is binding on the custodian.
Ark. Code Ann. § 20-18-304.

Requested Copies by Patients

The state registrar issues certified copies of vital records when requested by the registrant or the registrant's spouse, child, parent, guardian, or representative. Others may be authorized to obtain certified copies if they can demonstrate that the record is needed to determine or protect property rights.
Ark. Code Ann. § 20-18-305.

Amending Vital Records

Vital records may be amended as per the regulations issued by the state registrar. The regulations allow minor changes or additions made within one year without engaging the amendment process.
Ark. Code Ann. § 20-18-307.

Birth Certificates

Births in an Institution

A certificate of birth must be filed with the Division of Vital Records when a live birth occurs. The certificate must be filed within ten days. Certificates filed after ten days but within one year may require additional evidence of support. Certificates filed after one year shall be marked "Delayed" and must meet other requirements as described below.

The person in charge of the institution or his authorized designee must obtain all the personal data, prepare the certificate, and certify by signature that the child was born alive at the place, time, and date on the certificate. The physician attending the birth must provide the appropriate medical information needed for the certificate within 72 hours after the birth.

Births outside an Institution

When a birth occurs outside an institution, the attending physician or physician attending after the birth should file the birth certificate. If the birth occurs on a "moving conveyance within in the United States," the birth is registered in the state and place where the child is removed from the conveyance.

Mother and Father

Unless state law or a court determines otherwise, the mother of the child shall be the woman giving birth to the child. Surrogate mothers should be listed as the natural mother on the child's birth certificate. A court may subsequently order a substituted birth certificate.

If the mother *was married* at conception, birth, or in between conception and birth, her husband shall be listed as the child's father. This shall not apply if a court determines paternity as otherwise or if the mother, husband, and putative father all execute an affidavit stating that the putative father is the child's father. In that case, the child's putative father shall be shown as the father on the birth certificate. The parents may give the child any surname they choose.

If the mother *was not married* at the time of conception, birth, or in between, the name of the father should not be listed on the birth certificate. The father may be listed if the mother and the person to be named father execute an affidavit of paternity. The child may be given any surname.

When the name of a father is not listed on the certificate, no other information about the father may be listed.

Either parent of the child must verify the personal data of the certificate before filing.

Delayed Registration of Birth

Births reported over one year after birth must be registered on a delayed certificate. The delayed certificate must show the date of registration and contain a summary of evidence supporting delayed registration. "No delayed certificate of birth shall be registered for a deceased person."

The state registrar may refuse certification if the certificate is submitted with deficient documentation or a question as to validity exists. The state registrar must advise the applicant of the reasons for denying registration and of the right to appeal the decision.
Ark. Code Ann. § 20-18-401, 20-18-402; 9-10-201..

Death Certificates

A death certificate must be filed with the Division of Vital Records within ten days after death or finding of a dead body. Depending on the circumstances, death certificates can be prepared by physicians, medical examiners, coroners, or registered nurses. When a funeral director sends a death certificate to the treating physician for the physician to certify the cause of death and to sign and return the death certificate, the physician has two business days in which to do so. A 2009 change in the law empowers the Arkansas State Medical Board to enforce this time period.

Physicians may hear references to a "fact of death record." This record, created by a 2007 change to the law, applies to funeral directors and requires them to file the fact of death record within three days of the death or the finding of a dead body. The fact of death record does not replace the death certificate.

When a person dies of a contagious disease, physicians should notify the funeral

director in writing of the danger involved before the funeral director takes possession of the body, by use of the death certificate or other writing *Ark. Code Ann. § 20-18-601 and following; Arkansas Department of Health Rules and Regulations Pertaining to Vital Records §8.4 (1996).* *See also Contagious Diseases.*

Date of Death

When the date of death cannot be determined, it should be determined by approximation. If an approximation cannot be made, the date the deceased was found should be used.

Place of Death

The place where death is pronounced constitutes the place of death. If the place of death is unknown, the place where the body was found should be listed as the place of death. Deaths occurring on moving conveyances should identify the place of death as the state and place where the body is first removed.

Delayed Registration of Death

Death certificates filed over ten days after death must meet State Board of Health regulation requirements. Delayed registration not supported by the required documentation or of questionable validity may be refused by the state registrar. The registrar must advise the applicant of the reasons of refusal and of the right to appeal the decision. *Ark. Code Ann. § 20-18-602.*

New Information on Cause of Death

A physician providing medical certification of death must file a supplemental report with the Division of Vital Records upon receiving autopsy results or other information changing the cause of death.

Fetal Deaths

Fetal deaths must be reported within five days after delivery if the fetus weighed 350 grams or more. If weight is unknown, a report must be made if the fetus completed 20 weeks of gestation, as calculated from the date of the last normal menstrual period prior to delivery. Spontaneous fetal deaths in which the fetus weighed less than 350 grams or completed less than 20 weeks of gestation must be reported within five days of death by the institution or physician attending the death. "Spontaneous fetal death" means a situation in which the fetus is expelled or extracted from the mother's body but which is not an abortion.

The death certificate must be prepared by the person in charge of the institution or his representative. If the fetus is delivered outside an institution, the attending physician should prepare the certificate. Fetal deaths occurring without medical attendance are reported by the medical examiner or coroner.

Induced termination of pregnancy (abortion), regardless of length of gestation, must be reported within five days by the person in charge of the institution, or the attending physician if performed outside an institution.

Reports should not contain "the name or other personal identification of the person having an induced or spontaneous termination of pregnancy."

A person required to file a fetal death certificate of a stillborn child must advise the parents of two things: (1) that they may, but are not required to, request the preparation of

certificate of birth resulting in stillbirth by contacting the Division of Vital Records of the Department of Health and (2) how to contact the division. *Ark. Code Ann. § 20-18-410, Act 509 of 2007.*

Medical Certification of Death

The funeral director is obligated to provide a partially filled out death certificate that contains sufficient information to identify the decedent to the certifier of the cause of death. The physician in charge of the patient's care for the illness or condition that resulted in death has two business days after receiving the death certificate from the funeral director in which to complete, sign and return the death certificate to the funeral director. Exceptions to this time period are when either the State Crime Lab or a coroner is investigating the death. The Arkansas State Medical Board will enforce the two-day time period by its rules.

In the absence of the physician, or with his approval, the certificate may be completed by an associate physician, the chief medical officer of the institution in which death occurred, the pathologist performing the autopsy, or by a registered nurse employed by the attending hospice. Theregistered nurse may complete the certification only if the patient was terminally ill, death was anticipated, the patient received service from a certified hospice program, and the patient died in the hospice inpatient program or as a hospice patient in a nursing home. If a hospice patient dies at home, a registered nurses may make only a "pronouncement" of death; the coroner and the chief law enforcement officer must be immediately notified.

Individuals listed above other than the physician may verify the death certificate and cause of death only if they possess access to the decedent's medical history, "have reviewed the coroner's report if required," and death is due to natural causes. *Ark. Code Ann. § 20-18-601, as amended by Act 702 of 2007 and Act 1288 of 2009.*

Final Disposition of Body or Fetus

The physician certifying the cause of death must authorize the removal of a dead body from the place of death by the funeral director before preparation for final disposition. The physician must assure the director that death was from natural causes and assume responsibility for the certification.

Ark. Code Ann. §§ 20-18-601 to 604, as amended by Act 702 of 2007, and Act 1288 of 2009. Arkansas Dept. of Health Rules and Regulations Pertaining to Vital Records Reg. 7.2 & 7.3 (1996).

Identification of Deceased Infected by a Communicable Disease

A physician believing that a deceased person may have been infected with a communicable disease must attach a red indicator tag "to the large digit of the right foot" immediately after death. If the body is wrapped in plastic or other covering, a duplicate tag should be attached on the outside of the covering.

The Arkansas Department of Health supplies such tags. If the appropriate tag is unavailable, a tag at least three inches by five inches clearly stating the suspected communicable disease should be used.

Ark. Dept. of Health Rules and Regs. Pertaining to Communicable Diseases, Sec. XII.Arkansas Department of Health Rules and Regulations Pertaining to Vital Records, Regulation 8.3 (1996).

When to Refer the Case to the State Medical Examiner

When cause of death is from a condition other than the one the physician treated or other inquiry is required, the physician should refer the case to the State Medical Examiner or coroner. *See below.*

If inquiry is required, the State Medical Examiner or county coroner determines cause of death and completes the medical certification within 48 hours after taking charge. If cause of death cannot be determined within 48 hours, the attending physician, State Medical Examiner, or county coroner must notify the funeral director of the reason for delay.

When to Refer the Case to the Coroner or Law Enforcement

The state law requiring physicians to notify a county's chief law enforcement officer of deaths in specific circumstances may be pre-empted in part by the federal Health Insurance Portability and Accountability Act (HIPAA) because the state law does not limit reporting requirements to situations in which the physician suspects the death may have resulted from criminal conduct and thus may run afoul of HIPAA's Privacy Standard. Physicians should consult legal counsel on this issue. The HIPAA Privacy Standard does permit a physician to disclose Protected Health Information (PHI) to a coroner for the purpose of identifying a deceased person and determining a cause of death.

Under state law, physicians must promptly notify the county coroner and a chief law enforcement official in certain situations. These situations include when death appears to have been caused by the following: (1) violence, homicide, or suicide; (2) accident; (3) drugs or poison; (4) motor vehicle accident, with or without signs of trauma to the body; (5) fire or explosion; (6) drowning; or (7) criminal abortion.

Furthermore, notice must be given when (1) one finds the body near a roadway or railroad; (2) death occurs without explanatory medical history while the person is in a state mental institution or hospital; (3) death occurs when the person is in police custody, a jail, or a penal institution; (4) death of a minor appears to indicate child abuse ; (5) human skeletal remains are found; (6) decomposition exists precluding determination of injury or circumstances indicating a crime; (7) an infant or minor dies; (8) the death appears to be other than natural; (9) the death occurs suddenly and without explanation; (10) the death occurs at a work site; (11) no physician attended the decedent within the 36 hours preceding death; (12) no physician attended the decedent within 30 days preceding the death of a prediagnosed terminal or bedfast person; (13) death occurs in the home; (14) an unidentified deceased person is discovered; or (15) the death poses a potential threat to public health or safety.

Finally, a physician must notify the coroner and a law enforcement official when an unconscious and unresponsive person is brought to the emergency room, cardiopulmonary resuscitation is performed, but the patient dies within 24 hours of admission without gaining consciousness or responsiveness. This rule does not apply when the physician attended the patient within 36 hours preceding the hospital visit or when the patient suffers from a prediagnosed terminal or bedfast condition, unless more than 30 days have passed since the last physician visit.

See also, Death, Dying and Disposition of the Dead at page 62.

Ark. Code Ann. § 12-12-315, as amended by Acts 194 and 594 of 2007, and Acts 165 and 1286 of 2009.

Duty of the Arkansas Children's Hospital

In cases of sudden death of a child between the ages of one and six with no prior major medical health problems, the State Medical Examiner may authorize the Arkansas Children's Hospital to perform a postmortem examination. Postmortem examinations may be made without any consent.

If the hospital determines that death was caused by "foul play or criminal act," it must immediately notify the State Medical Examiner and the chief law enforcement officer where the death occurred. The proper evidentiary procedures must be followed.
Ark. Code Ann. § 12-12-318.

See Reporting, Mandatory Physician, Sudden Infant Death Syndrome at page 226.

WORKERS' COMPENSATION

Regardless of fault, employers are obligated to pay compensation to their employees for disability or death arising from an event occurring during the course of employment. However, there is no employer liability when the employee's injury results from the employee's intentional act.

Occupational diseases that result in the disability or the death of an employee generally entitle the employee or his dependents to workers' compensation payments. Occupational diseases are those that arise out of or during the course of employment, or those which naturally result from an injury.

The Arkansas Workers' Compensation Commission's rules may be accessed on the Commission's Internet website, www.awcc.state.ar.us.

There are now 39 rules. Topics range from the judicial to the administrative, from medical to safety, from employer duties to employee rights, and from the commission's rulemaking procedure to deviation from those rules.

For more information, contact the Legal Advisor Department of the Workers' Compensation Commission at 324 Spring Street, P.O. Box 950, Little Rock, Arkansas, 72203, (800) 250-2511 or (501) 682-3930.

Services at the Employer's Expense

The employer provides most medical services and supplies for an injured employee. The employer must provide "such medical, surgical, hospital, chiropractic, optometric, podiatric, and nursing services and medicine, crutches, ambulatory devices, artificial limbs, eyeglasses, contact lenses, hearing aids, and other apparatus as may be reasonably necessary in connection with the injury received by the employee." Emergency treatment shall not be at the claimant's expense. "In no circumstance" may an employee be billed or charged for any portion of the cost of providing the Workers' Compensation benefits to which he or she is entitled.

If the employer has a contract with a Managed Care Organization (MCO) certified by the Commission, the employer selects the initial primary care physician from among the MCO physicians.

The employee is allowed to change physicians one time by petitioning the Commission. Subject to certain rules, the transfer of care may be made to another MCO physician or the employee's regular treating physician, who must have a history of providing regular treatment to the employee prior to the compensable injury. If the employer does not have a contract with a MCO certified by the Commission, the employee will still be allowed to change physicians only once. The employee will be allowed to change to a physician who is associated with a MCO or is the employee's regular treating physician.

Two conditions must be satisfied prior to the treatment of an injured employee by a regular treating physician. First, the regular treating physician must agree to refer the employee to a certified managed care entity if any specialized treatment becomes necessary. Also, the regular treating physician must agree to follow the rules, terms, and conditions of the managed care entity originally chosen by the employer.

Physical Examinations

Injured employees must submit to a physical examination when they file a claim for compensation with the commission. Physicians selected and paid for by the employee, employer, or insurance carrier may participate in the physical examination if requested by the employee, employer, or insurance carrier.

Duty to Provide Information

Hospitals and physicians providing medical service to injured employees must allow records connected with the service to be copied and must furnish written information as requested. The Workers' Compensation Fraud Investigation Unit, the employer, the insurance carrier, the employee, the employee's dependents, or attorneys for any of them may make such a request. The medical service provider incurs no liability for furnishing such record or information in good faith. The cost of the copies must be paid to the provider of the medical services by the one requesting such information. The law changed in 2007 on permissible fees that can be charged for copies of medical records. By regulation and statute, the cost of photocopies, excluding X-rays, is limited now to $0.50 a page for the first 25 pages and $0.25 for each additional page. A labor charge not exceeding $15.00 may be added for each request for medical records for use in the Workers Compensation proceedings. The actual cost of any required postage may be charged. Other fees may also be permissible. An itemized invoice must accompany the copies. Providers should check current Workers Compensation Commission Rules or ask their legal counsel to determine whether other fees may be charged.

Payment for Service While Claim is Pending

When a physician or other health care provider has provided treatment of a work-related injury and has received written notice that a Worker's Compensation claim has been filed, it is illegal for the physician or other health care provider to bill or to attempt to collect any fee or a portion of any fee, or to report the employee to a credit bureau for failure to pay for the services. Health care providers are deemed to have actual notice of the filing of the claim five days after a notice is sent by certified mail to them. If an injury is later found to be not covered by Worker's Compensation, health care providers may pursue the employee for unpaid charges.

Ark. Code Ann. §§ 11-9-108, 118, 508, 511, 514, 516, and 601; Arkansas Workers' Compensation Commission Rules.