

THE LEGISLATIVE BULLETIN

A PUBLICATION OF THE VERMONT MEDICAL SOCIETY

Summer Update

ACT 75: PRESCRIPTION DRUG ABUSE PREVENTION AND MONITORING: IMPLEMENTATION TIMELINE

In response to increased opioid addiction and methamphetamine abuse in the state, the Vermont General Assembly passed Act 75, which Governor Shumlin signed on June 5, 2013. The act includes a number of provisions that are applicable to physicians, including that dosage be written in numeric and word form, and a requirement to register, and in some circumstances, query the Vermont Prescription Monitoring System (VPMS).

Links for Act 75: www.leg.state.vt.us/docs/2014/Acts/ACT075sum.htm (summary) & www.leg.state.vt.us/DOCS/2014/ACTS/ACT075.PDF (full text)

Below is a timeline for a number of Act 75's physician requirements:

Effective on passage: June 5, 2013

- **Dosage must be written in numeric and word form**

For all controlled substances – written or typewritten prescriptions must include the quantity of the drug written in both **numeric** and **word** form, similar to using numeric and word form when writing a check. This requirement does not apply to electronic prescriptions.

- **Prescription must include patient's date of birth**

Prescriptions for controlled substances must include the patient's date of birth.

Effective July 1, 2013:

- **Physicians' delegates are authorized to query the Vermont Prescription Monitoring Data Base**

Delegates are defined as individuals employed by physicians or other health care professionals who are authorized by a physician or other health care professional to request information from the Vermont Prescription Monitoring System (VPMS) database relating to current patients of the health care professional. Delegates must be registered with the VPMS and must certify that the requested information is for the purpose of providing medical or pharmaceutical treatment to a current patient. While using delegates has been sanctioned by the Department of Health for some time, the practice is now formally authorized by law.

- **Physicians licensed in other states are authorized to query VPMS**

Physicians licensed in other states, who register with the Vermont Prescription Monitoring System (VPMS), are authorized to query the VPMS database, to the extent necessary to provide appropriate medical care to a Vermont resident.

Effective October 1, 2013:

- **Specific requirements for "replacement prescriptions" for controlled substances**

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HIPAA AND HITECH – WHAT’S NEW: HIPAA OMNIBUS RULE

The HIPAA (Health Information Portability and Accountability Act) Omnibus Rule (Final Rule) made a number of changes and additions to the HIPAA privacy rules and the HITECH (Health Information Technology for Economic and Clinical Health Act) rules. **The compliance date for most of these new provisions is September 23, 2013.** The changes in the rule include the requirements described below.

Notice of Privacy Practices

The rules require several updates to the Notice of Privacy practices that you give to your patients. New content is required for the Notice of Privacy Practices including :

- A required header (This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully);
- A statement describing when an authorization is needed for use or disclosure of health information;
- A statement about an individual’s right to receive breach notifications;
- A statement addressing the restriction of psychotherapy notes from being shared (if applicable);
- If a physician practice engages in fundraising, a statement that the patient may opt out of fundraising communications;
- A statement addressing marketing, sale of health information and other uses that require patient’s written authorization; and
- A statement that the physician practice must agree to restrict disclosure **to a health plan** if the patient pays out-of-pocket in full for health care services

A notice of privacy practices that includes material revisions, may be distributed to patients by posting on the practice’s website and including in the next annual mailing to patients or by mailing to individuals within 60 days of revision. (See, Model Notice of Privacy Practices at www.vtmd.org/sites/default/files/files/HIPAA_Notice_of_privacy_%20practices2013.pdf)

Patient’s right to Request Restrictions – Private Payment

The rules require physician practices to agree to a patient’s request to restrict disclosure of protected health information to a **health plan** if the information pertains to health care for which the individual has paid the physician in full out-of-pocket and the disclosure is not required by another law. With respect to follow-up care, the individual must pay out of pocket and request restriction for follow-up care. The individual also has the obligation to request a restriction from downstream providers, but physicians are encouraged to assist patients in notifying downstream providers of the individual’s desire to restrict.

Patient’s Right to Electronic Access

If a patient requests an electronic copy of protected health information maintained electronically in a designated record set, the practice must provide access in the electronic format requested if it is readily producible or if that format is not available, in another readable electronic format agreed to by the practice and the patient. The physician can provide a hard copy if the patient declines to accept any of the electronic formats used by the practice.

The practice may charge for the reasonable costs of the electronic media (CD, USB drive) and the labor for copying the record, including the time for reviewing the request and producing the copy.

Genetic Information

Under the rule, genetic information must be treated as “protected health information” Health plans may not use or disclose genetic information for underwriting purposes.

Student immunizations

The rules make it easier for parents to permit physicians to release student immunization records to schools. A physician may disclose proof of immunization to schools in states with school entry laws with oral or written agreement of a parent. Oral agreement should be noted in the medical record.

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MEDICARE PAYMENT TRANSITION FROM NHIC TO THE NATIONAL GOVERNMENT SERVICES MEDICARE ADMINISTRATIVE CONTRACTOR (MAC)

CMS awarded the contract for Medicare Part B claims administration for Jurisdiction K, which includes Vermont, to National Government Services, Inc. (NGS), a subsidiary of Wellpoint. National Government Services will administer Medicare Part A and Part B claims for covered services in the states of Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island and Vermont (Jurisdiction K), and will also manage home health and hospice claims. Currently Medicare Part B claims are processed by NHIC, Corp. The transition date for Part A claims is October 18, 2013 and for Part B claims is October 25, 2013. NHIC, Corp., which has been the Part B carrier for Vermont for many years, will provide some services to National Government Services. Dr. Craig Haug will continue to serve as medical director.

NGS has an E-mail Updates Program on the NGS Jurisdiction K transition website that will provide details of the National Government Services Jurisdiction K transition, as available - <http://bit.ly/16jmIlZ>. More information about transitioning from a fiscal intermediary/carrier to a Medicare Administrative Contractor (MAC), is available from CMS - www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/SE1017.pdf

VPMS

(Cont'd from pg. 1) Specific requirements for “replacement prescriptions” go into effect on October 1, 2013. Act 75 defines a “replacement prescription” as “an unscheduled prescription request in the event that the document on which a patient’s prescription was written or the patient’s prescribed medication is reported to the prescriber as having been lost or stolen. A replacement prescription does not include a prescription refill, or a prescription that is changed for clinical reasons, for example in response to side effects or when a trial of a particular drug is not effective.

When a patient, parent or guardian requests a replacement prescription for a Schedule II, III, or IV controlled substance, the patient’s physician must query the VPMS prior to writing the replacement prescription. When a physician writes a replacement prescription for any controlled substance, the physician must write the word “Replacement” on the face of the prescription and document the writing of the replacement prescription in the patient’s medical record.

Effective November 15, 2013:

- **Prescribers must register with VPMS.**

Each health care professional who prescribes any Schedule II, III, or IV controlled substances must register with the VPMS by November 15, 2013. If the VPMS shows that a patient has filled a

prescription for a controlled substance written by a health care professional who is not a registered user of VPMS, the Commissioner of Health will notify the professional by mail and will notify the applicable licensing authority - for physicians either the Vermont Board of Medical Practice or the Vermont Board of Osteopathic Physicians. Link to Department of Health website for VPMS registration: healthvermont.gov/adap/VPMS.aspx

- **Prescribers must query the VPMS.**

Beginning on November 15, 2013, prescribers must query the VPMS in the following four circumstances:

1. At least annually for patients who are receiving ongoing treatment with an opioid Schedule II, III, or IV controlled substance;
2. When starting a patient on a Schedule II, III, or IV controlled substance for nonpalliative long-term pain therapy of 90 days or more;
3. The first time the provider prescribes an opioid Schedule II, III, or IV controlled substance written to treat chronic pain; and
4. Prior to writing a replacement prescription for a Schedule II, III, or IV controlled substance.

More information about the VPMS is available at the Department of Health website: healthvermont.gov/adap/VPMS.aspx.

HIPAA OMNIBUS RULE

(Cont'd from pg. 2)

Research

The rules allow researchers to use a single authorization for more than one research purpose and relax the policy on authorization for future research.

Marketing

Communications physicians make about health-related products and services are considered marketing if a third party pays for the communication, and require patient authorization. The authorization must state that the communication is paid for. A single authorization may be obtained to permit communications subsidized by multiple third parties. The authorization does not need to be limited to a single product/service or a single third party. Refill reminders and communications about generic equivalents do not require authorization.

Decedent Information

The rules make it easier to provide access about decedents' information to friends and families. The privacy protections are limited to 50 years after death. Physicians may disclose decedents' protected health information to family members and others involved in caring for the decedent prior to death, unless the disclosure is inconsistent with the prior expressed preference of the decedent. Information is not considered protected health information after the 50-year period expires.

Business Associates

The original HIPAA rule (1996) focused on ensuring providers and health plans protected patient's health information. The HIPAA Omnibus Rule (Final Rule) extends these requirements to include "business associates" including contractors and subcontractors. Under the new rules, business associates must comply with all requirements of the Security Rule, including the physical, administrative and technical safeguards required for protected health information.

The Department of Health and Human Services (HHS) has posted an updated Sample Business Associate Agreement on the HHS Office of Civil Rights website - www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/contractprov.html. Under the HIPAA Final Rule, providers are required to update existing agreements or put new agreements in place by September 2014. You must have a written

contract with each of your business associates, which must address a number of specific issues.

Breach Notification

The HIPAA Omnibus Rule (Final Rule) creates a new standard for breach notification, that replaces the previous "harm" standard. Breach is now defined as an "impermissible use or disclosure of unsecured protected health information," without requiring any showing of harm. A breach is presumed to require notification, unless the covered entity or business associate can demonstrate a low probability that the protected health information has been compromised based on a risk assessment of the following four factors:

- Nature and extent of the protected health information involved;
- Who received or accessed the protected health information;
- Potential that the protected health information was actually acquired or viewed; and
- Extent to which the risk to the data has been mitigated.

Use of the risk assessment is only required if you want to demonstrate that no notification is required. If you believe that a breach involving use or disclosure of unsecured protected health information has occurred, you must notify patients that the breach of their information has occurred. If the breach involves more than 500 patients, you must notify prominent media outlets and the Secretary of Health and Human Services in addition to notifying the affected individual. Breach reports can be filled out and submitted at the HHS website. If the breach involves fewer than 500 individuals, the practice must notify the Secretary on an annual basis.

Additional information on VMS website:

- Updated model Notice of Privacy Practices:
www.vtmd.org/sites/default/files/files/HIPAA_Notice_of_privacy_%20practices2013.pdf
- Resources for Small Practices:
www.vtmd.org/hipaa-links-and-resources
- Free CME on HIPAA Compliance:
www.vtmd.org/cme-courses