HOSPICE ENDNOTES
for the North Carolina Hospice Community from Poyner Spruill LLP

SEPTEMBER 2010

CPR Training with the Health Law Section

Would you trust this lawyer to save your life? On June 11, the entire PS Health Law Section received CPR training and certification from the Triangle Area Chapter of the American Red Cross.* We're pretty sure we're the only law firm Health Law Section in the country that can honestly say, "We can save your license AND your life."

Jessica Lewis, an attorney and registered nurse, is certified in Basic Life Support for Health Care Providers through the American Heart Association.

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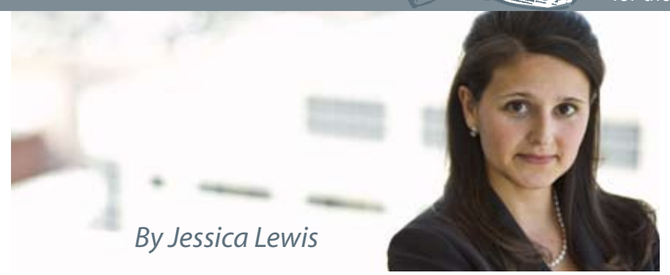
Hospice Cap Rule Bites the Dust Before Another Court

By Jessica Lewis

Since our update to you in the November 2009 edition of *EndNotes*, a few more U.S. district courts have declared the hospice cap regulation invalid because it is inconsistent with the statute on calculating the annual hospice cap. (See *Compassionate Care Hospice v. Sebelius*, No. 09-28-C (W.D. Okla. June 7, 2010); *Tri-County Hospice v. Sebelius*, No. 09-407-RAW (E.D. Okla. March 8, 2010); H*ospice of New Mexico LLC v. Sebelius*, 691 F. Supp.2d. 1275 (D.N.M. 2010); *Lion Health Services v. Sebelius*, 689 F. Supp.2d. 849 (N.D. Tex. 2010).) In these cases, these Courts enjoined the U.S. Department of Health and Human Services (HHS) from applying the regulation to calculate hospice cap liability and demand repayment from these hospice providers. The common ground among these cases is the conflict between the statutory mandate that a provider's number of beneficiaries for a fiscal year be reduced to reflect the proportion of hospice care that each beneficiary was provided in a previous or subsequent accounting year, and the regulation's failure to allow for apportionment, instead assigning a beneficiary's allocation for the year based only on the beneficiary's date of admission. According to the court in *Compassionate Care Hospice*, the inconsistency between the statute and regulations became problematic when the definition of persons eligible for hospice care changed to include patients suffering from diseases other than cancer, resulting in the addition of new patients to hospice care with longer lengths of stay per patient. These changes, among others, resulted in Medicare overpayment demands while the statute intended only to cap total Medicare reimbursement in a fiscal year for all of a hospice's patients. These recent decisions bolster the ability of a hospice faced with an overpayment demand to pursue and seek a remedy, at least in the form of a preliminary injunction, to enjoin HHS from collecting on the repayment demand until further law is made or reconsideration occurs.



By Jessica Lewis

Decision-Making Issues – Advance Directives Q&A

In the November 2009 edition of *EndNotes*, we published a Q&A tailored specifically to assist hospice providers with common decision-making issues related to hospice patients (those with a medical condition that a physician has certified as incurable or irreversible and likely to result in death in a relatively short period of time). No Q&A can exhaust the plethora of unique issues a provider might face in dealing with advance directives made by its patients. The following series of questions and answers is intended to supplement the first series published in November 2009. This edition of *EndNotes* also includes a workplace poster designed to help your staff understand health care decision-making processes for those patients who cannot make or communicate their own decisions.

Q My patient suffers from memory loss, intermittent confusion and disorientation, and his physician thinks that my patient has not been competent to make or communicate his own health care decisions for some time now. My patient has no power of attorney with health care decision-making powers nor does he have a living will. His wife is deceased, but he has one adult daughter. He also has an elderly girlfriend who sometimes visits and frequently calls him. The girlfriend has just provided me with a copy of a health care power of attorney, naming her as agent to make health care decisions for my patient, but the health care power of attorney was signed by my patient just yesterday. Is this health care power of attorney valid? May the girlfriend make health care decisions for my patient now?

A Probably not. A person can make an advance directive only while he or she is of sound mind and able to make and communicate health care choices. Given what you know of your patient's mental status and the timing of the execution of the power of attorney, it is questionable at best that your patient was "of sound mind and able to make and communicate health care choices" at the time he executed that health care power of attorney. Normally, a health care provider is statutorily protected from civil or criminal liability for relying in good faith on an advance directive that later turns out to be invalid. See N.C. Gen. Stat. § 32A-40. But in this case, you have reason to doubt the validity of the health care power of attorney.

When a patient has no valid advance directive and is incompetent to make/communicate his own health care decisions, there is a statutory line-up of individuals who have priority to make health care decisions for that patient. See N.C. Gen. Stat. § 90-21.13 and the workplace poster in this publication. The patient's adult daughter has priority over the patient's girlfriend (with the invalid health care power of attorney) to make health care decisions for the patient. It may be necessary, however, should the girlfriend persist in her attempts to control the patient's health care choices, for the daughter to bring a petition in superior court for adjudication of incompetency of and appointment as guardian for the patient, in order to assert her decision-making priority over that of the girlfriend.

Q My patient might need a guardian, but what is a guardianship and how is it implemented?

A A guardian is an individual or an agency (like the county Department of Social Services) that is court-appointed to manage a person's financial affairs (guardian of the estate) and/or personal decisions and affairs (guardian of the person). Pursuing guardianship is a multistep process, beginning with petitioning the superior court to declare a person incompetent to manage his or her own decisions and affairs and identifying an appropriate person or agency to be appointed as guardian for the incompetent person (the ward). A guardian will not be appointed unless and until the court has received sufficient evidence that the proposed ward is incompetent. Once a person is

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RALEIGH CHARLOTTE ROCKY MOUNT SOUTHERN PINES WWW.POYNERSPRUILL.COM
301 Fayetteville St., Suite 1900, Raleigh, NC 27601/P.O. Box 1801, Raleigh, NC 27602-1801 P: 919.783.6400 F: 919.783.1075

By Jennifer Parser

From Russia, With Love

The U.S. Department of Labor predicts a growing need for registered nurses due to an aging population and technological advances that emphasize preventive health care. In fact, health care is one of the two industry sectors expected to have the largest employment growth, adding 4 million jobs between 2008 and 2018.* To fill this need, employers will have to hire more foreign nurses and health care professionals. There are a variety of nonimmigrant and immigrant visa options for foreign nurses. Let's look at them.

Nonimmigrant or Temporary Work Visas for Nurses

Before either an immigrant or a nonimmigrant visa can be issued to a foreign nurse, a VisaScreen certificate must be granted by the Commission on Graduates of Foreign Nursing Schools (CGFNS). This certificate signifies that the applicant's education, training, license and experience are the equivalent of a U.S. nurse's of the same type; the appropriate license is unrestricted; and the applicant is fluent in English. Certain nurses are exempt from the equivalency evaluation and English language proficiency testing if their degree is from Australia, Canada (English-speaking territories only), Ireland, New Zealand, South Africa, the United Kingdom, or the United States. The CGFNS, the International Commission on Healthcare Professions (ICHP) and the Educational Testing Service Test of English as a Foreign Language administer the VisaScreen and English language tests, respectively. A VisaScreen is valid for five years. Additionally, the registered nurse or professional nurse must have a full and unrestricted license to practice professional nursing in the state of intended employment or evidence of having passed the examination offered worldwide by the National Council of State Boards of Nursing. The examination is known as the National Council Licensure Examination (NCLEX-RN). North Carolina requires the NCLEX-RN as well as the CGFNS VisaScreen or alternatively an educational evaluation from the CGFNS, the International Education Research Foundation or Josef Silny & Associates. If the nursing program was not taught in English, North Carolina will accept the Test of English as a Foreign Language, the Test of English for International Communication Service International Examination or the International English Language Testing System.

The following nonimmigrant visas are available only to registered nurses. Licensed practical nurses and licensed vocational nurses must apply for a permanent resident visa and, upon approval, wait for a visa number to become available, since only a limited number are available annually.

TN Visa

A registered nurse who is a Canadian or Mexican national (not necessarily born there) can work in the United States as a TN visa holder under the North American Free Trade Agreement. In addition to being qualified as a nurse by their home country, such registered nurses must have been certified by CGFNS and its ICHP division to obtain the VisaScreen certificate. If approved for TN visa status, Canadian nurses do not need the actual visa inserted in their passports, but Mexican nurses must obtain the visa at a U.S. Consulate in Mexico. The TN visa is issued for one year, and extensions can be indefinite and up to three years in length per extension. Although extendable indefinitely, the TN visa carries with it strong nonimmigrant intent, so that its issuance is dependent upon the TN visa holder continuing to demonstrate ties with Canada or Mexico and an intent to return there at the expiration of the authorized stay.

H-1B Visa

The H-1B visa option is for a "specialty occupation," which is normally an occupation requiring a U.S. bachelor's degree or equivalent. This can sometimes be used for RNs, but not always, since it's possible to be an RN without getting a U.S. bachelor's degree or its foreign equivalent. However, if the RN's practice area requires four years of postsecondary education, he or she may qualify for H-1B visa status. Some examples of nurses who require more advanced training to meet the standard to qualify for an H-1B are clinical nurse specialists, nurse practitioners, certified registered nurse anesthetists, nurse managers or supervisors, and critical care nurses.

To obtain any of the above visas, all registered nurses must pass the national licensing exam, NCLEX-RN. In addition, a registered nurse must meet state licensing requirements where he or she will practice and be certified by the CGFNS for the VisaScreen certificate.

Immigrant or Permanent Resident Visas for Nurses

Only registered nurses or physical therapists are exempt from labor certification, the first step to permanent U.S. residence. Labor certification is the process of proving to the U.S. Department of Labor that the prospective employer unsuccessfully attempted to hire a U.S. worker, either a U.S. citizen or a permanent resident, through a detailed recruitment process. Unlike registered nurses, licensed practical nurses and licensed vocational nurses are not exempt from the labor certification process. As a result, they can only be hired through the lengthy immigrant or permanent resident visa process that includes the labor certification component. Therefore, since licensed practical nurses and licensed vocational nurses are not eligible for nonimmigrant visas, they must wait abroad until the labor certification process is complete, the immigrant visa is approved and there is a visa available to them. This results in a long delay, since the nursing profession falls into an immigrant visa category known as the third preference, which includes only a limited number of visas annually and is perennially oversubscribed. Even though registered nurses and professional nurses are listed on Schedule A, Group I as precertified for employment in the United States by the Department of Labor, the third preference category still applies to them, so they also have a lengthy wait. The challenge to an employer is to keep them in the United States in nonimmigrant visa status while waiting for a permanent resident visa to be both approved and available.

The date on which a petition for permanent residence is filed is extremely important because this is the date, known as the "priority date," that places the applicant in line for a visa. A nurse can change employers once the application is approved, even if a visa is not available, and retain the same priority date. Once a visa becomes available, a nurse may only apply to adjust status to permanent resident from within the U.S. if here on a valid nonimmigrant visa with the CGFNS certificate, a full and unrestricted RN license in the state of the intended employment or proof of passing the NCLEX, and a VisaScreen.

The process for bringing nurses to the United States is highly technical and can be frustrating. With immigration reform on the horizon and a long-standing nursing shortage in the U.S., we hope the number of visas available to nurses will be increased and the lengthy waits decreased.

Jennifer Parser may be reached at jparser@poyners.com or 919.783.2955, is licensed in the state of New York and is not licensed in North Carolina.

**Bureau of Labor Statistics, Employment Projections: 2008-2018 Summary for December 11, 2009*

New Health Care Decision Poster

We love getting comments and ideas from you, our readers. Rod Baird, administrator for Extended Care Physicians, PA, of North Carolina, wrote to us in April and said, "You might want to consider rewriting & formatting the section of the law governing the hierarchy of 'legal representatives' authorized to give consent for medical care so it is a stand-alone poster that facilities could place on their walls. It might help their staff sort out this incredibly complex and frustrating topic." Well, Rod, here you go! We hope this "fill in the blanks" poster is helpful to you and to all readers. If you would like extra copies of the poster, please email reply@poyners.com with your request and include your name, facility, address, and number of copies you need.

Advanced Directives Q&A

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adjudicated incompetent, the person becomes a ward of the state and a guardian of the person and/or estate (or a general guardian) is appointed. According to NC statutes, a guardian of the person (or a general guardian) has first priority to make health care decisions for her ward, with one exception . . .

Q My patient has a recently appointed general guardian – her son. Ever since I began to provide care to her, she has had an agent under a health care power of attorney – her daughter. The son and daughter seemed to harmoniously work together to make the best decisions they could for their mother. But my patient's son and daughter are now at odds over an important decision about my patient's health care. There is no one else to intercede. To whom do I listen – the guardian (son) or agent under the health care power of attorney (daughter)?

A Look at the statutory order of priority (set forth in our workplace poster). You will see that a guardian like your patient's son has first order of priority for health care decision-making, UNLESS there is an unsuspended health care power of attorney. Your patient's daughter holds a health care power of attorney, so the question is whether the order appointing the son as guardian of your patient expressly suspended the powers of the daughter as agent under the health care power of attorney or whether the son as guardian separately petitioned the court for suspension of the health care power of attorney and prevailed. If not, the daughter's agency under the health care power of attorney still trumps the son's ability as guardian to make health care decisions.

As always, the goal is to act in the patient's best interest and in accordance with his or her wishes, subject to the parameters he or she has put in place while competent. For more specific issues with regard to advance directives, consult legal counsel.

Jessica Lewis may be reached at 919.783.2941 or jlewis@poynerspruill.com.

p.s. Poyner Spruill LLP
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