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Healthcare Law UPDATE

February 2021

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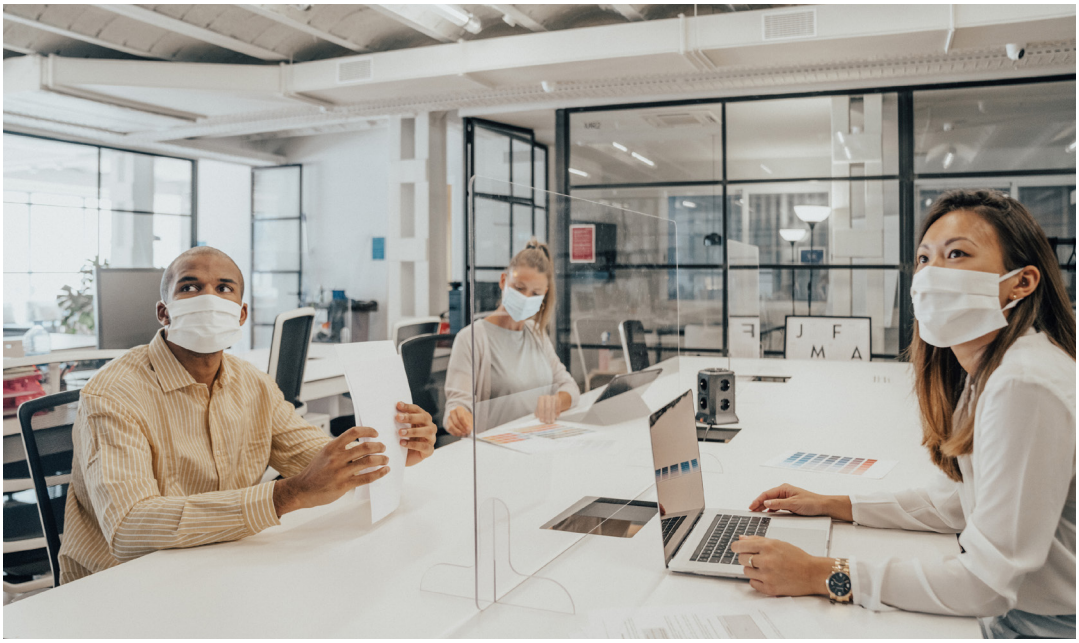
FEDERAL UPDATE

Mitigating the Spread of COVID-19 in the Workplace

President Biden issued an Executive Order on January 21, 2021, which seeks to ensure the health and safety of those in the workforce, especially those who are essential workers. The executive order called upon the Secretary of Labor, acting through the Assistant Secretary of Labor for Occupational Safety and Health, to issue no later than February 4, 2021, revised guidance to employers on workplace safety during the pandemic. In response to this Executive Order, the Occupational Safety and Health Administration (OSHA) issued guidance on January 29, 2021, to assist employers and employees with how to handle and identify risks associated with COVID-19 in the workplace, as well as how to put in place control measures to mitigate the spread of COVID-19.



OSHA recommends employers implement a COVID-19 prevention program and highlights that the implementation of such a program "is the most effective way to mitigate the spread of COVID-19 at work." In order to implement an effective program, OSHA recommends employers engage their employees and their respective representatives in developing and implementing such a program. OSHA recommends that a COVID-19 prevention program include 16 elements. Some of these elements include: (i) naming a workplace coordinator who will be responsible for COVID-19 issues on the employer's behalf; (ii) conducting a hazard assessment to identify possible exposure sites; (iii) identifying measures that will limit the spread of COVID-19, including implementing flexible work hours, teleworking, or improving ventilation; (iv) installing barriers when physical distancing cannot be maintained; (v) providing education to employees regarding COVID-19 policies and procedures; (vi) instructing workers who are infected or potentially infected to stay home and isolate or quarantine; (viii) not distinguishing between employees who are vaccinated and those who are not; and (ix) preventing retaliation and setting up an anonymous process for employees to raise concerns regarding COVID-19-related hazards.

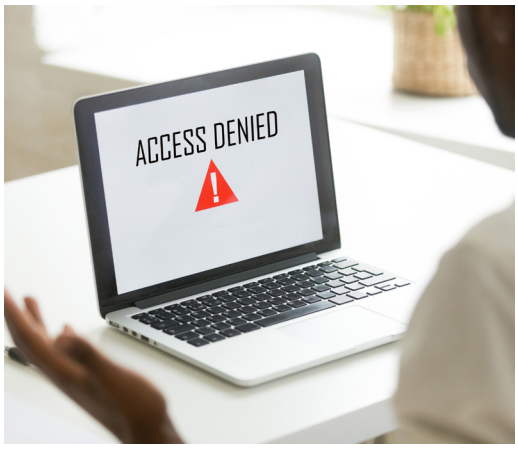
The Executive Order further asks OSHA to consider if any further emergency standards regarding COVID-19 need to be issued and, if necessary, such standards should be set forth by March 15, 2021. The same order seeks to review enforcement efforts by OSHA in order to identify any long- and short-term changes that will help better protect employees in the workforce and to promote multilingual outreach campaigns to ensure all employees and their representatives understand their rights.

For more information, contact:

Riza I. Dagli | 973.403.3103 | rdagli@bracheichler.com
John D. Fanburg | 973.403.3107 | jfanburg@bracheichler.com
Erika R. Marshall | 973.364.5236 | emarshall@bracheichler.com

The Open Notes Rule

The implementation of the Federal "Open Notes" rule is scheduled to take effect on April 5, 2021. The rule implements a portion of the Federal Cures Act related to information blocking, specifying that clinical notes are among electronic information that must not be blocked and must be available free of charge to patients. Generally speaking, such access is through a patient portal or health applications on smart devices.



With limited exceptions, the rule effectively grants patients with immediate access to health information in their electronic medical record, without charge by the provider, including the notes their clinicians write. More specifically, the rule covers the following eight types of patient data that is to be made available to patients electronically:

- Consultation Notes;
- Discharge Summary Notes;
- History and Physical;
- Imaging Narratives;
- Laboratory Report Narratives;
- Pathology Report Narratives;
- Procedure Notes; and
- Progress Notes.

The Open Notes rule applies to all healthcare providers, including but not limited to, hospitals, physicians, medical practices, ambulatory surgical centers, skilled nursing facilities, long-term care facilities and healthcare clinics, as well as health information exchanges and certified health IT developers.

For more information, contact:

Lani M. Dornfeld, CHPC | 973.403.3136 | ldornfeld@bracheichler.com
Carol Grelecki | 973.403.3140 | cgrelecki@bracheichler.com
Paul DeMartino, Jr. | 973.364.5228 | pdemartino@bracheichler.com

STATE UPDATE

Insurance Carrier Found Not Responsible for COVID-19 Coverage Claim

The Eye Care Center of New Jersey (Eye Care) stopped performing non-urgent procedures in accordance with government orders prohibiting such procedures due to the COVID-19 pandemic. Eye Care sought coverage from Twin City Fire Insurance Co. (Twin City) under a commercial insurance policy it had with Twin City for losses sustained as a result of COVID-19 restrictions. However, the insurance policy stated that Twin City "will not pay for loss or damage caused directly or indirectly by the presence, growth, proliferation, spread or any activity of…virus." Based on this exclusion, Twin City denied Eye Care's claim. Eye Care sued Twin City for breach of contract.

The judge dismissed Eye Care's coverage claims, stating that the exclusion barred coverage. The judge noted that the exclusion barred coverage for losses caused directly or indirectly by a virus and Eye Care's losses were caused directly or indirectly by the COVID-19 virus. The judge pointed out: "But for the 'spread' of COVID-19, governments would not have issued closure orders, and Eye Care would not have stopped performing non-emergency procedures." The judge noted that other courts in New Jersey have come to the same conclusion when presented with similar facts. Eye Care argued that the government orders, not the virus, should be considered the proximate cause of its losses. However, the judge was not persuaded by Eye Care's argument, as the exclusion stated specifically that coverage does not apply if losses are caused directly or indirectly by a virus, and the exclusion applies regardless of any other cause or event that contributes concurrently or in any sequence of the loss.

The case demonstrates the importance of providers reading their insurance policies carefully, as well as the importance of carefully examining choices relating to covered and uncovered claims when purchasing an insurance policy in the first instance.

For more information, contact:

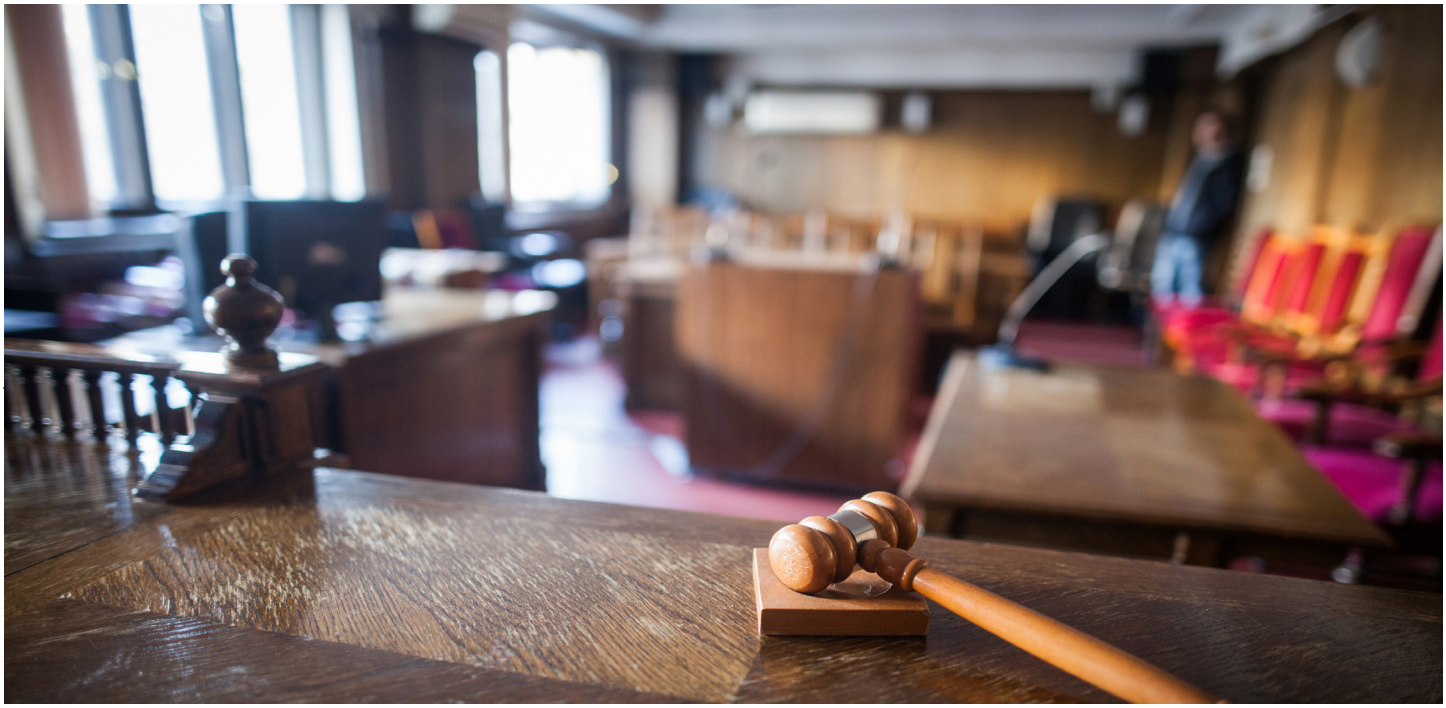
Joseph M. Gorrell | 973.403.3112 | jgorrell@bracheichler.com
Keith J. Roberts | 973.364.5201 | kroberts@bracheichler.com
Cynthia J. Liba | 973.403.3106 | cliba@bracheichler.com

NJ Doctors, Except for One Who Settled, Successfully Defend Appeal in Post-Surgery Med Mal Action

A New Jersey Superior Court Appellate Division affirmed a lower court's trial victory for doctors, nurses, and the affiliated surgical group and medical center in a medical malpractice suit that alleged they failed to properly treat a woman following surgery to remove a cancerous tumor. While one of the doctors reached a settlement with the plaintiffs, the rest of the defendants remained in the case relating to allegations of vicarious liability. Lauren Gill Hayser et al., v. Glenn Parker, M.D., et al., case number A-5531-17T1

The plaintiffs, a female patient and her husband, alleged that the defendants' negligence caused the patient to experience a bowel leak with fecal matter flowing into her peritoneal cavity, resulting in septic shock which led her to be re-hospitalized and remain intubated and sedated for a week. The patient was discharged 18 days after the initial surgery, after which she was admitted to a rehabilitation facility for eight days.

The plaintiffs alleged the defendants were negligent in the patient's post-surgical treatment, because they did not monitor, investigate, or report post-operative signs of infection after



removal of a malignant tumor. Although the patient initially showed no signs of infection, a few days after the surgery and for the next several days, her heart rate and white blood count fluctuated beyond the normal range. The plaintiffs alleged the nurses and doctors who treated the patient did not call for additional tests, even as hospital protocol required a nurse to notify a doctor if a post-operative patient's white blood count or pulse rate became elevated. The defendants argued that they checked her vitals as scheduled. At the time, the patient did not complain of pain, did not look sick, was making clinical progress, was healing, was not tired or confused, and had normal kidney function. After an 11-day trial, a New Jersey jury found that the treatment providers did not deviate from accepted standards of practice. The trial judge entered a final judgment dismissing the plaintiffs' claims with prejudice. The plaintiffs moved for a new trial, which was denied by the trial judge.

On appeal, the plaintiffs argued that the jury verdict was against the weight of the evidence and that there were errors made in the jury-selection process and during the trial that deprived the plaintiff of a fair trial. The plaintiffs' main arguments were that the trial judge erred in compelling too many sidebar conferences and for doing too much in open court, including questioning potential jurors. The court of appeals ruled, however, that the trial judge acted within his discretion in questioning jurors in open court. As to the allegations relating to jury selection, the appeals court stated, "[w]e see no evidence that the jurors who were impaneled — none of whom plaintiffs sought at any time to be excused — were biased against plaintiffs or their counsel or were otherwise tainted."

For more information, contact:

John D. Fanburg | 973.403.3107 | jfanburg@bracheichler.com
Carol Grelecki | 973.403.3140 | cgrelecki@bracheichler.com
James J. Ko | 973.403.3147 | jko@bracheichler.com

DOBI Data on Out-of-Network Arbitrations is Positive For Providers

As most New Jersey providers are aware, the New Jersey Out-of-Network Consumer Protection, Transparency, Cost Containment, and Accountability Act (P.L.2018, c.32) (Act), which took effect on August 30, 2018, prohibits providers from balance billing a covered person for inadvertent out-of-network services and/or out-of-network services provided on an emergency or urgent basis above the amount of the covered person's liability for in-network cost-sharing. The Act established an arbitration process to resolve out-of-network billing disputes between providers and insurance carriers (and self-funded plans that opt in to the arbitration provisions of the Act) for inadvertent and/or emergency/urgent out-of-network services. The New Jersey Department of Banking and Insurance ("DOBI") released data on January 31, 2021 detailing the status of arbitrations commenced under the Act for calendar year 2020, and the results are encouraging for providers.

As of December 31, 2020, MAXIMUS Federal, the DOBI contractor handling arbitrations under the Act, had received 5,715 arbitration requests, of which 4,173 were resolved by decision, 813 were dismissed as ineligible, and 729 cases were withdrawn. Of the 4,173 arbitration awards issued, providers prevailed in 2,683 cases or 64% of the total, while insurance carriers prevailed in 1,489 cases or 36% of the total. Providers were awarded $31.4 million, while awards to carriers were $5.2 million. Of the cases that were dismissed as ineligible, the primary reasons for dismissal were that the health benefits plan was issued in a state other than New Jersey or the plan was a self-funded plan that did not opt into arbitration. Further details on each arbitration filed can be found here.

Also noteworthy is that between January 1, 2020 and December 31, 2020, DOBI received just 76 consumer complaints relating to out-of-network healthcare charges.

The takeaway from this data is that providers should not be discouraged from pursuing arbitration if they dispute a carrier's or plan's fee for out-of-network inadvertent or emergency/ urgent services.

For more information, contact:

John D. Fanburg | 973.403.3107 | jfanburg@bracheichler.com
Keith J. Roberts | 973.364.5201 | kroberts@bracheichler.com
Susan E. Frankel | 973.364.5209 | sfrankel@bracheichler.com

New Jersey Legislative Update

New Law Requires Health Care Facilities to Report COVID-19 Data – On February 4, 2021, Governor Phil Murphy signed into law Bill S2384/A4129 to require healthcare facilities to report certain coronavirus disease 2019 (COVID-19) data related to

healthcare workers and certain first responders. Specifically, general acute care hospitals, special hospitals, ambulatory care facilities, ambulatory surgical centers, assisted living facilities, home health agencies, nursing homes, and hospice programs are required to report to the Department of Health (DOH) either directly or through a non-profit trade association, on a bi-monthly basis, de-identified data on the number of healthcare professionals, ancillary healthcare workers, and emergency medical services personnel employed by the facility who tested positive for COVID-19 and who died from COVID-19. The DOH will be required to issue a report concerning the occupational data received pursuant to the new law no later than 12 months after the end of both the state of emergency and public health emergency declared in response to the COVID-19 pandemic.

Executive Order Creates Interagency Health Care Affordability Working Group – On January 28, 2021, Governor Phil Murphy signed Executive Order 217 to create the Interagency Health Care Affordability Working Group. The Working Group will serve in an advisory capacity and report directly to the Office of the Governor. It will be chaired by the Director of the Office of Health Care Affordability and Transparency in the Office of the Governor. The other members of the Working Group will be the Commissioner or other agency head of the following departments and agencies: (i) the Department of Banking and Insurance; (ii) the Department of Human Services; (iii) the Department of Health; (iv) the Division of Consumer Affairs; and (v) the Department of the Treasury. Key objectives of the Working Group include the following:

- Developing and recommending policies to improve health care affordability, accessibility, and transparency for New Jersey residents;
- Recommending the development and coordination of programs and policies of the participating departments to support health equity for New Jersey residents; and
- Leveraging the State's existing data resources and identifying strategies for enhancing and integrating State data resources to develop cost-growth benchmarks to foster accountability and contain health care costs and to utilize the data to identify cost drivers to inform strategic and collaborative action by members of the Working Group and other relevant stakeholders throughout the State.

Within nine months following the organization of the Working Group, the Department of Banking and Insurance is to deliver to the Working Group a final report containing proposals for the development and implementation of cost growth benchmarks and health insurance affordability standards that will be applicable to both insurers and providers operating in the State's health care market. The report will be made available to the public at the same time. It will include a plan under which the State can implement cost growth benchmarks and health insurance affordability standards by January 1, 2022, and will identify all policy and legislative changes needed to effectuate cost growth benchmarks and health insurance affordability standards.

For more information, contact:

Joseph M. Gorrell | 973.403.3112 | jgorrell@bracheichler.com
Riza I. Dagli | 973.403.3103 | rdagli@bracheichler.com
Ed Hilzenrath | 973.403.3114 | ehilzenrath@bracheichler.com

Brach Eichler In The News

Congratulations to Healthcare Law Associates **Colleen Buontempo** and **Ed Hilzenrath** who were promoted to Counsel on March 1.

Managing Member and Healthcare Law Chair **John D. Fanburg** was named to *ROI-NJ's* Influencers: Power List 2021 for Health Care on February 22.

On February 6, Litigation Co-Chair and Healthcare Law Member **Keith J. Roberts** commented in *Law360* about the use of virtual jury trials and the need to move forward despite the pandemic.

Managing Member and Healthcare Law Chair **John D. Fanburg** provided insights on legal cannabis in New Jersey in *ROI-NJ* on January 25.

Join us for our next webinar, "COVID-19: The Lingering Effects of the Pandemic on Contractual Obligations" on Thursday, March 25 at 1:00 p.m. **John D. Fanburg** will moderate as Litigation Co-Chair **Rose Suriano** and Litigation Member **Stuart Polkowitz** discuss how force majeure provisions and other contractual elements have recently been interpreted by the courts. Click here to register.

HIPAA CORNER

The Department of Health & Human Services, Office for Civil Rights (OCR) has settled two more cases in the OCR's "right of access" initiative. There are now 16 published settlements in the initiative, and there are almost certainly more on the horizon.

The 15th settlement was by a private, not-for-profit health system in Nevada, that agreed to pay $75,000 to settle potential violations of HIPAA, and to enter into a settlement agreement with the OCR including two years of monitoring by the OCR. The conduct at issue was the failure by the provider to timely send a patient's records in a "designated record set" to a third party, the patient's attorney, as requested by the patient. In this instance, the request was not fulfilled until approximately 11 months after the request was made. Under HIPAA, the "designated record set" includes both the medical and billing records related to a patient's care.

In the 16th settlement, a not-for-profit regional healthcare group paid $70,000, and entered into a settlement agreement which included two years of monitoring for the alleged failure to provide electronic access to patient records, including after the OCR provided technical assistance after the patient first complained of the issue.

These settlements are yet another reminder of the OCR's dedication to ensuring patients are given timely access to their health records, including access to view and access to obtain copies in the form and format requested by the patient.

If you would like assistance with your HIPAA or 42 CFR Part 2 privacy and security program, in managing or reporting a breach incident, or in business associate analysis and contracting, contact:

Lani M. Dornfeld, CHPC | 973.403.3136 | ldornfeld@bracheichler.com

BRACH EICHLER LLC
Counsellors at Law

Healthcare Law Practice | 101 Eisenhower Parkway, Roseland, NJ 07068

Members

Riza I. Dagli | 973.403.3103 | rdagli@bracheichler.com
Lani M. Dornfeld, HLU Editor | 973.403.3136 | ldornfeld@bracheichler.com
John D. Fanburg, Chair | 973.403.3107 | jfanburg@bracheichler.com
Joseph M. Gorrell | 973.403.3112 | jgorrell@bracheichler.com
Carol Grelecki | 973.403.3140 | cgrelecki@bracheichler.com
Keith J. Roberts | 973.364.5201 | kroberts@bracheichler.com

Counsel

Colleen Buontempo | 973.364.5210 | cbuontempo@bracheichler.com
Shannon Carroll | 973.403.3126 | scarroll@bracheichler.com
Ed Hilzenrath | 973.403.3114 | ehilzenrath@bracheichler.com
Debra W. Levine | 973.403.3142 | dlevine@bracheichler.com
Jonathan J. Walzman | 973.403.3120 | jwalzman@bracheichler.com
Edward J. Yun | 973.364.5229 | eyun@bracheichler.com

Associates

Lindsay P. Cambron | 973.364.5232 | lcambron@bracheichler.com
Paul J. DeMartino, Jr. | 973.364.5228 | pdemartino@bracheichler.com
Susan E. Frankel | 973.364.5209 | sfrankel@bracheichler.com
James J. Ko | 973.403.3147 | jko@bracheichler.com
Cynthia J. Liba | 973.403.3106 | cliba@bracheichler.com
Erika R. Marshall | 973.364.5236 | emarshall@bracheichler.com

Roseland, NJ | New York, NY | West Palm Beach, FL | www.bracheichler.com | 973.228.5700