HEALTH CARE LAW ADVISOR ALERT: VACCINE INJURY CLAIMS AND THE FEDERAL VACCINE COURT

As the development of a potential COVID-19 vaccine continues, so too do questions about the types of vaccines being developed and how they will be administered. Vaccines offer overwhelming public health benefits, but a small number of individuals who receive vaccines are harmed by them. Most claims alleging health problems caused by vaccines must be brought in the "Vaccine Court" of the United States Court of Federal Claims under the National Childhood Vaccine Injury Act of 1986, 42 U.S.C. § 300aa-1, *et seq*.

The Act creates the National Vaccine Injury Compensation Program to handle vaccine-related claims. The program is administered by a secretary who may compensate a party who has suffered a vaccine-related injury or death. The Act largely preempts traditional tort claims against vaccine administrators or manufacturers for vaccine-related injuries and it limits claimants to only those sustaining injury or their legal representatives.

The Act creates a Vaccine Injury Table listing various vaccines and medical conditions that may result from them. Claimants must show, by a preponderance of evidence, that they suffered an injury listed in the Table or that a vaccine caused or significantly aggravated their injury within the time periods set forth in the Table. *Terran ex rel. Terran v. Sec'y of Health and Human Servs.,* 195 F.3d 1302, 1307 (Fed. Cir. 1999), *cert. denied,* 531 U.S. 812 (2000). If claimants do so for an injury listed in the Table within the time period stated in the Table, they are presumed to be entitled to compensation. *Knutson by Knutson v. Sec'y of Health and Human Servs.*, 35 F.3d 543, 547 (Fed. Cir. 1994). For claims not falling within the Table, claimants must prove the vaccine at issue caused their injury by a preponderance of evidence. *Golub v. Sec'y of Health and Human Servs.*, No. 99-5161, 2000 WL 1471643, at *2 (Fed. Cir. Oct. 3, 2000). Claimants are limited to a recovery of $250,000 for pain and suffering, but may recover additional damages for actual and projected un-reimbursable expenses, actual and anticipated lost earnings, and reasonable attorneys' fees and costs.

Claims made to the Vaccine Court are sent to the office of the Chief Special Master, who then assigns the claim to a special master to review and issue a decision to be entered as a judgment by the Federal Court of Claims. Either party can request that the Federal Court of

Claims review this decision, and also can seek further review in the United States Court of Appeals for the Federal Circuit. Judicial review of the special masters' decision is limited; the decision can be set aside only if either court determines it is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law. If claimants choose to reject a judgment by the Vaccine Court, they then may pursue a tort action in state or federal court. However, the Act offers certain defenses and presumptions to defendants facing such claims.

For more information about the Vaccine Court, or other legal issues relating to the COVID-19 pandemic, contact Grant Killoran of O'Neil, Cannon, Hollman, DeJong & Laing S.C. at 414-276-5000 or grant.killoran@wilaw.com.

HEALTH CARE LAW ADVISOR ALERT: TELEHEALTH IN WISCONSIN (PART 2 OF 2)

Medical Malpractice Risk & Telemedicine Policies

This article is the second of a two-part series on telehealth in Wisconsin. The first article of this series, available here, highlighted basic standards for regulatory compliance in the design of internal telehealth policies. This second article addresses the practitioner's obligation to minimize patient harm (and thus practitioner liability) with attention to the medical standard of care when assessing when and how telehealth is appropriate for each patient.

A. Maintaining Medical Standard of Care in Telemedicine

Wisconsin medical providers must critically evaluate whether their use of a telemedicine platform would permit their evaluation and treatment of each patient in compliance with "the standard of minimally competent medical practice."[i] Standards of practice and conduct required for in-person visits, including standards relating to patient confidentiality and recordkeeping, must be observed in the telehealth context.[ii]

In view of these standards articulated by the Wisconsin medical examining board, internal

telemedicine policies and procedures must preserve the same degree of quality and safety achieved during in person appointments. Clinical leadership must assess whether quality of patient care can be maintained via telehealth, an evaluation which is dependent upon the provider's area of specialty, the patient's condition, and other factors. For example, the use of telemedicine is not suitable for conditions where physical examinations are necessary, because of extreme symptoms, forceful interventions, or in the case of medical procedures for which certain protocols need to be followed.[iii]

Clinical guidelines specific to telemedicine can serve as important indicators as to whether your practice should incorporate telemedicine for specific patient encounters or diagnostic evaluations.[iv] However, guideline compliance does not guarantee accurate diagnosis or safe and effective medical care meeting the standard of care. Local circumstances must be considered, and the practitioner is ultimately responsible for all decisions regarding the appropriateness of a specific course of action.[v] Published guidelines for every clinical scenario and application simply do not exist and so by necessity may need to be developed in-house.[vi] The policies of each medical practice should delineate between circumstances in which various telehealth platforms can, and cannot, preserve the quality of care for patients. Providing treatment recommendations, including issuing a prescription, based only on a static electronic questionnaire does not meet the standard of minimally competent medical practice.[vii]

Sometimes the proper standard of care is reflected in government reimbursement decisions. For example, the Wisconsin Department of Health Services' ("DHS") expansion of telehealth coverage will exclude comprehensive assessment and care planning for children with complexities, since this requires an in-person assessment. However, case management for children with complex medical needs will be covered. Certain, but not all, dental evaluations will be covered. Certain therapy services will be covered.[viii]

Where clinical leadership determines that telehealth is appropriate, workflow must be re-evaluated in the telehealth context to maintain the standard of care. For example, staff responsibilities may require adjustment for telehealth encounters to ensure that updates to the medical record, physician orders and the "after visit summary" are properly recorded in connection with each telehealth encounter. Providers may consider requiring immediate scheduling of patients who express symptoms that require in-person evaluation during a telemedicine visit to promote patient safety and minimize liability. Providers might also consider whether patient/family coaching regarding medication administration is properly handled in the telehealth context.

B. Telephone and Texting: Risk Mitigation

While the use of synchronous audio and video visits has exploded in the wake of the COVID-19 pandemic, physicians have provided routine medical advice by phone for decades,

responding to patient calls reporting a change in condition and advising medication changes by phone communications. Surveys of patients since the COVID-19 pandemic indicates that texting is a preferred method of communication over phone calls.[ix] In addition to health care privacy and security issues (outside of the scope of this article), what are some of the legal considerations for such telephone and texting encounters?

First, practitioners must observe the criteria for government and private insurer reimbursement of telehealth, unless their practice is limited to self-pay. In the case of Medicaid reimbursement, the Wisconsin Medical Assistance Program generally covers consultations through "interactive telehealth" and certain asynchronous telehealth services and remote patient monitoring.[x] The Wisconsin Statutes delegate authority to DHS to determine whether to include telephone encounters within the definition of "telehealth."[xi] DHS is temporarily providing coverage for certain telephone visits during COVID-19 pandemic, and the agency may ultimately decide to continue coverage of certain telephone communications as part of its permanent policy.[xii] Audio-only telephone communications must be delivered with the functional equivalency of a face-to-face encounter in order to be covered by Wisconsin Medicaid during the COVID-19 pandemic.[xiii]

If the patient will be located out-of-state, the provider must assess whether the applicable state's criteria for Medicaid telehealth reimbursement differs from the requirements imposed by Wisconsin Medicaid.[xiv] If federal Medicare will instead serve as payor, the Centers for Medicare and Medicaid Services ("CMS") will reimburse certain audio-only phone visits during the COVID-19 public health emergency. For reimbursement purposes, CMS distinguishes "telephone visits" from "services that "would normally occur in person." Telephone visits are "not paid as though the service occurred in person," and reimbursement may be bundled into a pre- or post-service if the phone encounter falls within the previous seven days of a prior visit or leads to a subsequent evaluation/management service.[xv]

Because audio-only telephone and texting encounters are inherently more limited with respect to patient evaluation capabilities, providers should exercise caution when using these modes of telehealth in circumstances that would usually *or could* warrant a physical evaluation of the patient based upon medical history or the symptoms described when scheduling an appointment. In addition to introducing risk of medical malpractice claims, providers risk non-compliance with criteria for reimbursement, such the standard of "functional equivalency to the face-to-face service" required by state Medicaid for reimbursement. The "functional equivalency standard" applicable to state government reimbursement is higher than the "the standard of minimally competent medical practice" generally applicable to the practice of telemedicine in the state.[xvi]

C. Updates to Telehealth Policies and Procedures

Irrespective of whether government reimbursement is in play, your medical practice policies

and procedures should be updated to mitigate risk to patient care and safety in the telehealth context. Your internal policies and procedures should delineate between when telemedicine is (and is not) appropriate based upon a critical assessment of each of the several evaluative and diagnostic services provided by your practice. Staff, including schedulers and nurses, should be trained as to when scheduling a telemedicine appointment poses risk to your patients and your practice. Your policies should incorporate customized procedures designed to preserve the standard of care and the medical recordkeeping requirements imposed by the Wisconsin medical examining board for the practice of telemedicine. In addition, physicians practicing telemedicine should confirm that their medical malpractice insurance coverage applies outside of the traditional health care facility settings.

OCHDL's health care practice group will continue to monitor telehealth regulations and related guidance as the standard of care for telemedicine evolves. For more information on this topic, contact Marguerite Hammes at 414-276-5000 or marguerite.hammes@wilaw.com.

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[i] *See* WIS. ADMIN. CODE § MED 24.06.

[ii] *See* WIS. ADMIN. CODE § MED 24.05. (requiring the same standard of practice and conduct regardless of whether health care services are provided in person or by telemedicine). The standard of care that is required of all Wisconsin health care providers is defined as the degree of skill, care, and judgment which reasonable health care providers who practice the same specialty would exercise in the same or similar circumstances, having due regard for the state of medical science at the time. *Nowatske v. Osterloh*, 198 Wis.2d 419, 543 N.W.2d 25 (1996), *abrogated on other ground by Nommensen v. American Continental Ins. Co.*, 246 Wis.2nd 132, 629 N.W.2d 132 (2001); Wis. J.I. Civil No. 1023.

[iii] Secure Medical, Best Telemedicine Clinical Guidelines (April 13, 2018), available at https://www.securemedical.com/telemedicine/best-telemedicine-clinical-guidelines/

[iv] *E.g.,* American Telemedicine Association, Practice Guidelines Archives, available at https://www.americantelemed.org/resource_categories/practice-guidelines/ ; Pantanowitz, Liron et al. "American Telemedicine Association clinical guidelines for telepathology." Journal of pathology informatics vol. 5,1 39. 21 Oct. 2014, doi:10.4103/2153-3539.143329; Krupinski, Elizabeth A, and Jordana Bernard. "Standards and Guidelines in Telemedicine and Telehealth." Healthcare (Basel, Switzerland) vol. 2,1 74-93. 12 Feb. 2014, doi:10.3390/healthcare2010074.

[v] Elizabeth A. Krupinski and Jordana Bernard, Standards and Guidelines in Telemedicine and Telehealth, Healthcare 2014, 2, 74-93; doi: 10.3390/healthcare2010074, at 81.

[vi] *See* Standards and Guidelines in Telemedicine and Telehealth, Healthcare, supra note 5, at 81.

[vii] *See* WIS. ADMIN. CODE § MED 24.07 (2).

[viii] *See* Brook Anderson, Wisconsin DHS Benefits Policy Section Chief, Telehealth Expansion: Acute and Primary Services, available at https://www.dhs.wisconsin.gov/telehealth/telehealth-expansion-all-provider.pdf

(revised July 30, 2020).

[ix] SR Heath, Patient Communication Preferences: the COVID-19 Impact, July 30, 2020, available at https://mhealthintelligence.com/resources/white-papers/patient-communication-preferences-the-covid-19-imp act eid=CXTEL000000554482&elqCampaignId=16139&utm_source=ded&utm_medium=email&utm_campaign=dedicated&elqTrackId=607a1670c3c349349ac195f03c60cba2&elq=362f09f490fe41169f2fc16dbcab5410&elqaid=16904&elqat=1&elqCampaignId=16139

[x] *See* WIS. STAT. § 49.46(2)(b)(21)-(22).

[xi] *See* WIS. STAT. § 49.45(61)(a)(4); §49.46(2)(b)(23).

[xii] *See* ForwardHealth Update 2020-12, "Temporary Changes to Telehealth Policy and Clarifications for Behavioral Health and Targeted Case Management Providers" (revised May 8, 2020), available at https://www.forwardhealth.wi.gov/kw/pdf/2020-12.pdf

[xiii] *See id*.

[xiv] *See* Center For Connected Health Policy, State Telehealth Laws & Reimbursement Policies (Fall 2020), available at https://www.cchpca.org/sites/default/files/2020-10/CCHP%2050%20STATE%20REPORT%20FALL%202020%20FINAL.pdf

[xv] *See, e.g.,* Centers for Medicare and Medicaid Services, COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-For-Service (FFS) Billing (revised October 20, 2020), at 63-79, available at https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

[xvi] *Compare* Wisconsin ForwardHealth Telehealth Expansion and Related Resources for Providers, available at https://www.forwardhealth.wi.gov/WIPortal/content/html/news/telehealth_resources.html.spage , *with* WIS. ADMIN. CODE § MED 24.06.

HEALTH CARE LAW ADVISOR ALERT: TELEHEALTH IN WISCONSIN (PART 1 OF 2)

O'NEIL CANNON
HOLLMAN DEJONG & LAING S.C.

Wisconsin's Premier Lawyers & Litigators

I. Expansion of Telehealth to Meet Clinical Need

Federal and state governments have resolved traditional barriers to telehealth – including complexity of billing, lower reimbursement and privacy and security concerns – to facilitate the safe provision of medical services during the COVID-19 pandemic.[i] The first article in

this two-part series highlights basic standards for regulatory compliance in the design of telehealth policies. The second article will address the practitioner's obligation to minimize patient harm (and thus practitioner liability) with attention to the medical standard of care when assessing when and how telehealth is appropriate for each patient.

II. Mechanics of Telehealth Compliance

A. Minimum Standards for Telehealth Practice

A Wisconsin physician planning to provide treatment recommendations (including a prescription) by use of a website-based platform must observe requirements promulgated by the Wisconsin medical examining board to comply with state law and (when applicable) to receive payment from Wisconsin Medicaid.[ii] While the requirement that the physician be licensed to practice medicine in the state has been suspended during the COVID-19 emergency,[iii] the following formalities must still be observed during the pandemic to protect the integrity of the telemedicine encounter:

1. Physician's name and contact information must be made available to the patient;
2. Informed consent must be obtained;[iv]
3. A documented evaluation (including a medical history) must be performed. If needed to satisfy standards of minimally competent medical practice, an examination, evaluation, and/or diagnostic tests are also required.
4. A patient health care record must be prepared and maintained.[v]

Under permanent Wisconsin telemedicine regulations, a physician-patient relationship may be initially established by use of two-way electronic communications, but not by use of audio-only telephone, email messages or text messages.[vi] Conditioning treatment of a patient upon the use of telehealth is expressly prohibited.[vii]

B. Reimbursable Telehealth Services

1. Wisconsin Medicaid & Telehealth

Wisconsin lawmakers began expanding the services and communications that may be provided by telehealth prior to the COVID-19 pandemic. The Wisconsin Department of Health Services ("DHS") continues to broaden the range of medical services covered by the state's medical assistance program when delivered remotely, both during the public health emergency and beyond.[viii] DHS is adding Medicaid coverage for *currently covered services* when provided using a telehealth platform if *functionally equivalent to an in-person visit* (interactive synchronous technology).[ix] DHS's criteria for "face-to-face equivalence" for interactive telehealth services includes the use of "audio, video, or telecommunication technology," but only if there is "no reduction in quality, safety, or effectiveness."[x] Audio-

only phone communication that can be delivered with a functional equivalency to face-to-face service will be covered during the COVID-19 pandemic.[xi] DHS emphasizes that documentation must support the service rendered.[xii] For further explanation of these policies, visit ForwardHealth, Telehealth, Telehealth Expansion and Related Resources for Providers.[xiii]

Telehealth coverage expansion applies to all services currently indicated in topic (#510) of the FowardHealth Online Handbook (permanent policy), and additional services temporarily allowed for telehealth are published in ForwardHealth Updates.[xiv] For example, ForwardHealth is expanding coverage to include certain synchronous (real-time) and asynchronous (not real-time) services such as remote patient monitoring and provider-to-provider consultations. DHS also plans to roll out expansion updates particular to specific services areas, such as therapy and behavioral health. DHS will use a phased approach to its expansion of telehealth services, keeping providers informed of expansion of coverage via the ForwardHealth website described above.

In addition to coverage criteria relating to the mode of telehealth services, a provider must be mindful of rules governing the logistics of telehealth visits. Wisconsin Medical Assistance (Medicaid) places no restriction on the location of the provider (permanent policy), which may include physicians, nurse practitioners, Ph.D. psychologists, psychiatrists and others.[xv] Beginning in March 2020, ForwardHealth began allowing coverage irrespective of the location of the patient (permanent policy).[xvi] However, only the following sites are currently eligible for a facility fee: hospitals, including emergency departments, office/clinics, and skilled nursing facilities.[xvii]

2. Federal Medicare & Telehealth

The Centers for Medicare and Medicaid Services ("CMS") greatly expanded access to Medicare telehealth services based upon the regulatory flexibilities granted under Social Security Act § 1135 waiver authority and the Coronavirus Preparedness and Response Supplemental Appropriations Act. Currently, Medicare will reimburse both synchronous video visits and also brief communication technology-based services ("CTBS") for responses to Medicare Part B beneficiaries by telephone, audio/video, secure text messaging or by use of a patient portal.[xviii] Reimbursement for CTBS is limited to patients with an established (or exiting) relationship with a physician or certain practitioners. The billing codes for CTBS represent ***brief, patient-initiated*** communication services and do not replace full evaluation and treatment services covered under the Medicare benefit and described by existing CPT codes. To meet the criteria for medical necessity, CTBS must require clinical decision-making and not be for administrative or scheduling purposes. The patient must verbally consent to these types of services at least annually.

To be covered by Medicare, the CTBS must not be related to a medical visit within the previous seven (7) days and cannot lead to a medical visit within the next twenty-four (24) hours (or soonest appointment available).[xix] For Medicare reimbursement, providers must confirm that the particular diagnostic benefit falls within the description of CTBS codes. For example, CTBS codes do not include the audiology diagnostic benefit category.[xx] DHS applies similar requirements to billing for "telephone evaluation and management services" covered under Wisconsin Medicare.[xxi]

During the COVID-19 pandemic, Medicare will reimburse telehealth services at the same rate as regular, in-person visits. The level of reimbursement that is approved following the public health emergency will impact the availability of telehealth services.

C. Documentation Requirements

DHS policy (published via ForwardHealth updates available online) is to require that all services provided via telehealth be thoroughly documented in the member's medical record in the same manner as services provided face-to-face.[xxii] Providers must develop and implement their own methods of informed consent to confirm that a member agrees to receive services via telehealth. ForwardHealth considers verbal consent to receiving services via telehealth an acceptable method of informed consent when it is documented in the member's medical record.[xxiii] Documentation for originating sites (patient location) must support the member's presence in order to submit a claim for the originating site facility fee. In addition, if the originating site provides and bills for services and also the originating site facility fee, documentation in the member's medical record should distinguish between the unique services provided.[xxiv]

DHS is temporarily allowing supervision requirements for paraprofessional providers to be met via telehealth. Supervision must be documented according to existing benefit policy.[xxv]

III. Additional Considerations for Telehealth

E-Prescribing – Many states limit the prescribing of controlled substances based solely on telehealth examination. Generally speaking, the U.S. Drug Enforcement Administration ("DEA") requires a telemedicine provider to have an in-person medical evaluation of a patient prior to prescribing a controlled substance for the patient, absent an exception. However, the DEA issued notice in March 2020 that this requirement is waived for the duration of the COVID-19 public health emergency.[xxvi]

Privacy & Security – The Office for Civil Rights announced on March 17, 2020 that they will not impose penalties for noncompliance with the Health Insurance Portability and Accountability Act of 1996 regulatory requirements for remote communications technologies

in connection with the good faith provision of telehealth during the national COVID-19 public health emergency. DHS has issued an update clarifying guidance regarding federal enforcement of the Health Insurance Portability and Accountability Act of 1996 regulatory requirements during the COVID-19 pandemic.[xxvii]

<u>Practicing Telehealth Across State Lines</u> **–** Wisconsin has adopted the Federation of State Medical Boards' Interstate Licensure Compact, which aims to expediate physician licenses for uses like telemedicine in states that adopt the compact. Wisconsin providers serving patients in other states must consult local state laws governing the physician-patient relationship and the use of telemedicine.

When a Wisconsin provider provides telemedicine services to a patient located outside of the state, legal review for choice of law and choice of forum should be undertaken. For example, the laws of the state in which each patient is located should be evaluated for: (1) statute of limitations; (2) standard of care; (3) limitations of liability; and (4) unique provisions governing the establishment or termination of the physician/patient relationship. To manage these challenges in a large telemedicine practice, a provider may need to consider establishing different legal entities for the practice of medicine in different states.

OCHDL will continue to monitor changes in regulations and policy impacting telemedicine. Our next blog post will address medical malpractice risk and telemedicine policies. For more information on these topics, contact Marguerite Hammes at 414-276-5000 or marguerite.hammes@wilaw.com.

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[i] SR Health, A Complete Guide to Seeing Patients Virtually and Getting Paid for It, available at https://www.srhealth.com/resources/telemedicine-guide

[ii] *See* WIS. ADMIN. CODE § MED 24.07 (1).

[iii] In the ordinary course, a physician practicing telemedicine in Wisconsin must be licensed to practice medicine and surgery by the medical examining board as required by Wis. Admin. Code § MED 24.04. *See* Wis. Admin. Code § MED 24.07 (1). However, Wis. Admin. Code § MED 24.04 (requiring a physician practicing medicine in Wisconsin to be licensed by the medical examining board) and 24.07(1)(a) (applying licensing requirements to medical practice by telemedicine in the state) have been suspended during the COVID-19 emergency. *See* Governor Tony Evers Emergency Order #16 Related to Certain Health Care Providers and the Department of Safety and Professional Services Credentialing, dated March 27, 2020.

[iv] WIS. ADMIN. CODE § MED 24.07 (1) (citing WIS. STAT. § 448.30 and Ch. MED. 18).

[v] WIS. ADMIN. CODE § MED 24.07(1) (citing ch. MED. 21).

[vi] ***See id.*** **§ MED 24.03.**

[vii] **ForwardHealth Update No. 2020-09, "Changes to ForwardHealth Telehealth Policies for Covered Services, Originating Sites, and Federally Qualified Health Centers" (March 18, 2020).**

[viii] ***See*** **WIS. STAT. § 49.45(61)(b); § 49.46(2)(b)(21)-(23). DHS is expanding the permanent definition of telehealth to encompass the "practice of health care delivery, diagnosis, consultation, treatment, or transfer of medically relevant data by means of audio, video, or data communications that are used either during a patient visit or consultation or are used to transfer medically relevant data about a patient."** ***See*** **ForwardHealth, Telehealth, Telehealth Expansion and Related Resources for Providers, available at** https://www.forwardhealth.wi.gov/WIPortal/content/html/news/telehealth_resources.html.spage ***See also*** **Letter to ForwardHealth Providers from Jim Jones, State Medicaid Director, re: Wisconsin Medicaid Response to the COVID-19 Outbreak; FowardHealth #510.**

[ix] ***See*** **ForwardHealth Update 2020-09,** ***supra*** **note vii (permanent policy); ForwardHealth Update 2020-12, "Temporary Changes to Telehealth Policy and Clarifications for Behavioral Health and Targeted Case Management Providers" (Revised May 8, 2020); ForwardHealth Update 2020-15, "Additional Services to be Provided Via Telehealth" (Revised May 8, 2020) (temporary expansion policy).** ***See also*** **Brooke Anderson, Benefits Policy Section Chief, Telehealth Expansion: Acute and Primary Services, available at** https://www.dhs.wisconsin.gov/telehealth/telehealth-expansion-all-provider.pdf

[x] ***See*** **ForwardHealth, Telehealth, Telehealth Expansion and Related Resources for Providers,** ***supra*** **note viii.** ***See also*** **Brooke Anderson, Benefits Policy Section Chief, Telehealth Expansion: Acute and Primary Services,** ***supra*** **note ix.**

[xi] **ForwardHealth Update 2020-12,** ***supra*** **note ix.**

[xii] **ForwardHealth, Telehealth, Telehealth Expansion and Related Resources for Providers,** ***supra*** **note viii.**

[xiii] **For further explanation of these policies, visit ForwardHealth, Telehealth, Telehealth Expansion and Related Resources for Providers,** ***supra*** **note viii.** ***See also*** **Brooke Anderson, Benefits Policy Section Chief, Telehealth Expansion: Acute and Primary Services,** ***supra*** **note ix.**

[xiv] **ForwardHealth Update 2020-15,** ***supra*** **note ix.**

[xv] **ForwardHealth Update 2020-12,** ***supra*** **note ix (permanent policy with respect to provider location but temporary with respect to other policy changes).**

[xvi] **ForwardHealth Update 2020-09,** ***supra*** **note ix (permanent policy changes).**

[xvii] **ForwardHealth, Topic 510, Telehealth, available at** https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Print.aspx?ia=1&p=1&sa=1&s=2&c=61&nt=Telehealth

[xviii] **Centers for Medicare and Medicaid Services, Medicare Telemedicine Health Care Provider Fact Sheet, available at** https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

[xix] ***See id.***

[xx] **American Speech-Language-Hearing Association, Use of Communication Technology-Based Services During Caronavirus/COVID-19 (June 6, 2020), available at** https://www.asha.org/Practice/reimbursement/medicare/Use-of-E-Visit-Codes-for-Medicare-Part-B-Services-During-Coronavirus/

[xxi] **ForwardHealth Update 2020-09,** ***supra*** **note vii.**

[xxii] ForwardHealth Update 2020-12, *supra* note ix (citing Wis. Admin. Code § DHS 106.02(9); ForwardHealth Online Handbook #201 (Financial Records), #202 (Medical Records); #203 (Preparation and Maintenance of Records); #204 (Records Retention); #1640 (Availability of Records to Authorized Personnel)).

[xxiii] *See* ForwardHealth Update 2020-15, *supra* note ix.

[xxiv] *See* ForwardHealth Update 2020-12, *supra* note ix.

[xxv] *See id.*

[xxvi] DEA Press Release, DEA's Response to COVID-19 (March 20, 2020), available at https://www.dea.gov/press-releases/2020/03/20/deas-response-covid-19

[xxvii] *See* ForwardHealth Update 2020-12, *supra* note ix.

HEALTH CARE LAW ADVISOR ALERT: VIDEOCONFERENCING CONSIDERATIONS FOR HEALTH CARE LITIGATORS

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Wisconsin's Premier Lawyers & Litigators

These days, litigators are routinely taking depositions and participating in hearings over Zoom or other videoconferencing apps and software. Frequently, these depositions and hearings are set up using videoconferencing systems chosen, hosted, and controlled by a court, an arbitrator, or a court reporter. There has been significant discussion and administrative guidance about the use of videoconferencing by health care providers since the pandemic began. Health care litigators should also consider the implications of video depositions or hearings on HIPAA security obligations.

Zoom reports that it is HIPAA compliant. However, these features must be requested by the subscriber, typically through a Zoom for Healthcare subscription. Microsoft Teams also reports it is capable of HIPAA compliance, as does Google Meet.

Litigators who anticipate protected health information (PHI) may be discussed or contained in documents shared through a videoconferencing platform for purposes of a deposition or hearing should inquire with the host about the type of subscription and system capabilities. Some court reporters offer special HIPAA-compliant rooms with certain features disabled.

With the rapid transition to videoconferencing to conduct a substantial amount of litigation tasks, guidance in this area is likely to continue to evolve along with videoconferencing system capabilities. Health care providers and their outside litigators should stay informed and be prepared to ask the right questions to ensure they are not overlooking HIPAA obligations.

The attorneys who contribute to the Health Care Law Advisor are available to assist health care providers with a variety of legal matters. Please contact us if you need assistance navigating the pandemic-related changes to health care litigation.

HEALTH CARE LAW ADVISOR ALERT: WELL-DRAFTED ASSIGNMENT OF BENEFIT FORMS ARE CRITICAL WHEN FIGHTING ERISA CLAIM DENIALS

Most private health insurance coverage in the United States is employer-sponsored and governed by a federal law known as the Employment Retirement Income Security Act of 1974 (ERISA). Navigating an appeal of a benefit denial issued by an ERISA-governed health plan can be confusing. A quick review of federal regulations governing ERISA benefit denials, which can be found **here**, suggests how challenging it may be for health care providers to navigate the ERISA claims landscape successfully.

ERISA benefit denials are frequently written by a health insurer or third-party administrator (TPA) that is not the legal entity truly providing the health benefits to the patient. The legal entity providing the benefits—the health insurer**,** so to speak—is known as an "ERISA plan." When a health care provider obtains an assignment of its patient's benefits, those rights are against the ERISA plan, not necessarily the health insurer or TPA that may have written a benefit denial letter.

Health care providers can improve their chances of successfully recovering benefits from ERISA plans by ensuring that their Assignment of Benefit (AOB) forms are properly worded.

AOB forms should fully authorize a provider to pursue all of its patient's appeal rights under ERISA. In addition, AOB forms should allow a health care provider to obtain full information about the ERISA plan's benefits, so that the provider can properly assess what benefits are available for various medical procedures. Absent appropriate AOB language, a provider's billing administrators may find themselves stymied when attempting to obtain the health benefits that both the provider and patient deserve. A review of AOB form language may be warranted to ensure that a health care provider has the best possible chance of recovering benefits from ERISA plans successfully.

Doug Dehler is a shareholder and a member of the firm's Litigation group. Doug's practice includes advising clients on insurance coverage and health benefit issues.

HEALTH CARE LAW ADVISOR ALERT: SELLING YOUR MEDICAL PRACTICE? MAKE SURE YOU HAVE TAIL COVERAGE.

When selling a medical practice, the physician-owner must consider multiple issues. From understanding the significance of the letter of intent, to complying with medical record transfer laws, to negotiating the purchase agreement, it can feel overwhelming.

One item to not overlook is the importance of obtaining medical malpractice insurance tail coverage.

To understand what tail coverage is, it is first necessary to understand the difference between a claims-made malpractice insurance policy and an occurrence-based malpractice insurance policy. To have coverage under a claims-made policy, the claim for coverage must be made while the insurance policy is in effect. Occurrence-based insurance, on the other hand, focuses on when the incident giving rise to the claim for coverage occurred. If a covered incident occurs while the occurrence-based insurance policy is in effect, coverage may be available even if the alleged bodily injury is not discovered until years later. So, tail coverage is necessary for claims-made insurance policies, but not for occurrence-based insurance policies. Tail coverage applies to claims-made insurance policies because the "tail"

extends the insurance coverage beyond the termination date of the claims-made policy. This is critical because, by obtaining tail coverage, the insured physician will continue to have malpractice coverage for incidents that happened prior to the termination date of the policy, even if the claim occurs after the termination date.

With this termination date often being the date on which the physician sells his or her medical practice, this tail coverage provides valuable peace of mind and liability protection for the selling physician. Accordingly, selling physicians with a claims-made medical malpractice insurance policy should consult their advisors, including their insurance agent, to ensure that tail coverage is in place in connection with the sale of their practice.

Jason Scoby is a shareholder and a member of the firm’s Business Law, Mergers and Acquisitions, and Banking, Receivership, and Creditors’ Rights Practice Groups. He advises and represents individuals, businesses, and banks on a variety of corporate, banking, and business-related issues, including mergers and acquisitions, commercial loan transactions, corporate issues, contract negotiation and preparation, and business entity selection and formation.

OCHDL CREATES NEW HEALTH CARE LAW BLOG

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Wisconsin’s Premier Lawyers & Litigators

Welcome to the first edition of the O’Neil, Cannon, Hollman, DeJong & Laing Health Care Law Advisor. We have created this blog as an informational and educational resource for our clients and contacts. The health care industry changes often and quickly, and we seek to help keep you apprised of important legal developments in the health care field.

Over the past few months, we have spent significant time advising clients on issues relating to the COVID-19 pandemic. We include in this inaugural blog post links to some of our recent writings regarding COVID-19 issues, including links of two cover stories in *The Wisconsin Lawyer* magazine. *The Wisconsin Lawyer* is the monthly publication of the State Bar of Wisconsin and addresses issues of interest throughout the state and country.

Christa Wittenberg and Grant Killoran authored the cover article in the April, 2020 edition of *The Wisconsin Lawyer* entitled “Due Process in the Time of the Coronavirus.” Their article

analyzes legal concepts governing the measures utilized by public health officials to combat an outbreak of contagious disease, focusing on COVID-19. Their article can be found here.

Grant Killoran, Joe Newbold and Erica Reib authored the cover article in the June, 2020 edition of *The Wisconsin Lawyer* magazine entitled “The New Wave of Litigation: An Early Report on COVID-19 Claims.” Their article analyzes the types of claims being made related to the COVID-19 pandemic. Their article can be found here.

We also include a link to a recent article on our firm’s Employment LawScene blog related to the COVID-19 pandemic entitled IRS Says Reduced-Cost or Free COVID-19 Testing or Treatment Won’t Prevent Individuals from Making or Receiving HSA Contributions.

Lastly, in conjunction with last week’s start of the Major League Baseball season, we include a link to an article recently posted in our newsroom by Attorneys Austin Malinowski, Pete Faust, and Kelly Kuglitsch entitled COVID-19 Raises Privacy Issues for Major-League Baseball. The article discusses not only the current state of privacy policy in the baseball world, but also reviews the obligations of other businesses under the ADA, FMLA, CARES Act, GINA, and HIPAA.

We hope you enjoy this blog. If you have any questions about any of the articles or issues discussed in it, please feel free to contact the authors.