MARTIN CLEARWATER & BELL LLP

DEFENSE PRACTICE UPDATE

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New York's Paid Family Leave Law: What Employers Should Know and How to Prepare

BY: GREGORY B. REILLY AND MELANIE M. GHAW

On July 19, 2017, the New York State Workers' Compensation Board adopted final regulations to implement the New York State Paid Family Leave Benefits Law ("PFL"). Although the PFL is not effective until January 1, 2018, the final regulations are effective immediately. To ensure legal compliance – and to avoid potential liability – covered employers must navigate the complexities of the PFL to effect successful integration of the new leave law with the existing local, state, and federal leave laws.

What is the PFL?

The PFL – a series of amendments to the New York State Workers' Compensation Law – will provide eligible employees with job-protected leave and partial wage replacement to care for a close relative with a serious health condition, to bond with a new child (birth, adoption, or foster care), or for qualifying exigencies arising from a family member's active duty military service. The PFL cannot be used for an employee's own serious health condition or qualifying exigency.

Covered Employers

A "covered employer" is defined to include private employers with one or more employees working in New York State for 30 or more days in a calendar year. Generally, most employers covered under the New York State Workers' Compensation Law will be covered under the PFL.

Since the PFL is intended to benefit employees who work in New York State, an employee can be eligible for PFL benefits even if their residence or employer is located outside the state.

Eligible Employees

Employees who work for a covered employer and are regularly scheduled to work 20 or more hours per week will become eligible after 26 consecutive weeks of employment. Employees who work for a covered employer and are regularly scheduled to work less than 20 hours per week will become eligible after working 175 days. Since the PFL is intended to benefit employees who work in New York State, an employee can be eligible for PFL benefits even if their residence or employer is located outside the state.

Qualifying Events

Bond with a child:

An employee may take leave to bond with a child during the 52-week period following the child's birth, or placement of an adopted or foster care child. An employee may take leave before the placement of an adopted or foster care child, if an absence is necessary for the placement

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An employer must maintain the employee's health insurance coverage while the employee is on PFL. Upon an employee's return from PFL, the employer must reinstate the employee to the same or a similar position with comparable pay, benefits, and terms and conditions of employment.

to proceed. If an employee takes leave prior to the actual placement of an adopted or foster care child, the employee's PFL entitlement will expire 52 weeks from the first date of leave taken to facilitate the placement.

Care for a close relative with a serious health condition:

An employee may take leave to provide care for the serious health condition of a spouse, domestic partner, child, parent, parent-in-law, grandparent, or grandchild. A serious health condition means "an illness, injury, impairment, or physical or mental condition that involves: inpatient care in a hospital, hospice, or residential health care facility; or continuing treatment or continuing supervision by a health care provider."

Qualifying exigencies:

An employee may take leave to manage family affairs arising from the active duty military service of the employee's spouse, domestic partner, child, or parent.

Employer Obligations

An employer must maintain the employee's health insurance coverage while the employee is on PFL. Upon an employee's return from PFL, the employer must reinstate the employee to the same or a similar position with comparable pay, benefits, and terms and conditions of employment.

An employer must provide its employee with the option to file a waiver of PFL benefits if: (1) the employee is regularly scheduled to work 20 or more hours per week but will not work 26 consecutive weeks; or (2) the employee is regularly scheduled to work less than 20 hours per week but will not work 175 days in a period of 52 consecutive weeks. An employee who files a waiver is exempt from the required contribution to PFL benefits through payroll deductions.

Employee Notice Requirements

When the need for PFL is foreseeable, the employee must provide at least 30 days' advance notice prior to the commencement of leave. When the need for PFL is unforeseeable, the employee must provide notice as soon as practicable – generally, on the same or next business day after learning of the qualifying event.

PFL Integration and Interplay

FMLA and PFL

If an employee is eligible for leave under the FMLA and PFL, the employer may designate the leave to run concurrently, provided the employer notifies the employee of such designation and provides the employee with notice as required under the FMLA. An employer who fails to provide an employee with the required notices may not designate the leave to run concurrently.

Short-Term Disability and PFL

Although an employee may be eligible for disability benefits and PFL benefits, an employee may not concurrently receive benefits under disability and PFL. Additionally, the combined duration of benefits may not exceed 26 weeks during a 52-consecutive week period.

PTO and PFL

An employer may not require an employee to take PTO concurrently with PFL; however, an employee may elect to take PTO concurrently with PFL to receive their full salary during leave.

NYC Earned Sick Time Act and PFL

If an employee is eligible for leave under the NYC Earned Sick Time Act and PFL, the employee may elect to take PFL concurrently with time available under the NYC Earned Sick Time Act to receive their full salary during leave.

Funding PFL Benefits

The PFL will be funded by employee contributions through deductions from each employee's paycheck. The maximum employee contribution for 2018 will be 0.126 percent of an employee's weekly wage up to, and not to exceed, the annualized state average weekly wage as determined by the New York State Department of Financial Services. Employers are permitted, but not required, to collect payroll deductions at any time before the effective date of January 1, 2018.

PFL Phase-In Schedule

Year	Duration Benefit Period	Weekly Cash Benefit Rate
2018	8 weeks	The lesser of 50% of the employee's average weekly wage; or 50% of the state average weekly wage.
2019	10 weeks	The lesser of 55% of the employee's average weekly wage; or 55% of the state average weekly wage.
2020	10 weeks	The lesser of 60% of the employee's average weekly wage; or 60% of the state average weekly wage.
2021	12 weeks	The lesser of 67% of the employee's average weekly wage; or 67% of the state average weekly wage.

The New York State Department of Labor computed the current state average weekly wage to be $1,305.92. The re-calculated state average weekly wage will be reported by the Commissioner of Labor to the Superintendent of Financial Services on March 31st of each year.

Takeaways

Prior to January 1, 2018, employers should:

- Obtain and display the required poster to ensure employees are aware of the PFL
- Amend existing policies or provide written guidance to inform employees of their rights and obligations under the PFL, including information on filing claims
- Coordinate with payroll services to implement the PFL payroll deductions
- Revise leave policies to ensure proper administration of leave under the various programs

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Case Results

June 2017: Senior Trial Partner **Peter T. Crean**, assisted by Partner **Kevin P. McManus**, received a defense verdict in Supreme Court, Queens County before Justice Pam Jackman Brown. The case involved a 60-year-old married mother of five adult children. The primary allegation is a failure to diagnose lung cancer in the setting of spinal complaints which became Stage IV spinal metastasis. Plaintiff had been hospitalized for spinal complaints and left on her own without further investigation. She subsequently returned to our defendants. The focus of the case related to her reporting to our client, her primary care physician, that a mass had been found on her lung during the hospitalization which was then not adequately further investigated before metastasis. Plaintiff had a prolonged and sympathetic demise which included pancreatic cancer said to have been metastasis. At trial, we were successful in asserting a liability defense that our physician had not departed from the standard of care. We also asserted a proximate cause defense that the cancer had already spread to the spine before her complaints and that the subsequent pancreatic cancer was in fact an independent primary cancer from which she died. The jury returned a defense verdict.

June 2017: Senior Trial Partner, **William P. Brady**, assisted by Senior Associate **Samantha E. Shaw** and Associate **Michelle A. Frankel** obtained a defense verdict in Supreme Court, Bronx County before Judge Alison Tuitt. The case

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Metadata and Medical Malpractice

By: Nancy J. Block and Michelle A. Frankel

Medical malpractice litigation has changed in many respects since the increased implementation and mandated use of electronic medical records (EMR). One critical area concerns the issue of metadata. By now, most of us are at least somewhat familiar with metadata – the information hidden behind data that provides details pertaining to the data itself. Before the advent of EMR, it was only the visible text of a medical record that was questioned by plaintiff's attorneys and had to be defended by doctors. Gaps in the record would generally be filled in with testimony from physicians and medical personnel. Now, metadata may provide additional information that was previously unknowable and is potentially relevant to claims and defenses. Such information may include identities of practitioners who reviewed a chart, when and what portion of a chart was viewed, changes to notes, and more. It is therefore incumbent on defense counsel to be mindful early on in a case if metadata is relevant to the claims and will likely play a role – beneficial or not. From a discovery standpoint, it is equally important to appreciate when such data is irrelevant and appropriately protect against its disclosure.

What Is Metadata and When is it Discoverable?

In malpractice litigation, New York courts have yet to extensively address the discoverability of metadata. However, several trial court decisions are instructive and can provide guidance. In *Vargas v. Lee*[1], Kings County Supreme Court Justice Gloria M. Dabiri defined metadata as electronically stored information (ESI) that describes the "history, tracking or management of an electronic document" and includes the "hidden text, formatting, codes, formulae and other information associated" with an electronic document.[2] She identified different types of metadata and commented that "system metadata" includes data concerning "'the author, date and time of creation, and the date a document was modified.'"[3] Judge Dabiri also addressed the audit trail – commonly demanded in malpractice cases when metadata is sought. She found that the EMR audit trail constitutes "system metadata" because it is an "automated set of chronological records of system activities that may enable the reconstruction and examination of a sequence of events and/or changes in an event."[4] Certainly, information about user access and activity may be relevant, if not crucial, in some malpractice cases. Given its potential relevance, it is understandable why there has been much contention over the discoverability of the audit trail. Nevertheless, courts have generally held that most system metadata (which includes the audit trail) lacks evidentiary value and is not relevant. Following this general principle, metadata is not routinely produced in malpractice cases unless the requesting party shows that it is relevant and not privileged.[5] More important, the metadata must also contain information that is unavailable through other sources for it to be discoverable.

Specifically, in *Vargas,* plaintiffs sought to compel the defendant Wyckoff Heights Medical Center (Wyckoff) to produce the audit trail for the plaintiff's EMR. Plaintiffs claimed that the audit trail was relevant to the issue of proper and timely treatment of post-surgical complication – a common allegation. Wyckoff objected to the disclosure by arguing that the demand was not relevant to any issue that was to be litigated. Justice Dabiri sided with defense counsel and held that the plaintiffs were not entitled to the audit trail because plaintiff "ha[d] not distinguished the audit trail's utility from that of its corresponding EMR. Plaintiff [could] presumably obtain the patient's treatment details from the already produced EMR."[6] Judge Dabiri protected the audit trail from disclosure as plaintiffs failed to articulate specific and unique information that it contained which was crucial to their case – the EMR itself was sufficient.

Challenges to the authenticity of a document might also call for the discoverability of metadata. Additionally, questions may arise as to a physician's awareness of a change in a patient's condition. In these situations, a key issue in plaintiff's case may be when, or if, a practitioner accessed a portion of the EMR and presumably became

1. 2015 N.Y. Misc. LEXIS 2176, 2015 NY Slip Op 31048(U) (Sup. Ct., Kings County 2015).
2. *Id.* at **3-**4, citing *Aguilar v. Immigration & Customs Enforcement Div. of U.S. Dep't of Homeland Sec.,* 255 F.R.D. 350, 352 (S.D.N.Y. 2008) and *The Sedona Principles, Second Edition: Best Practices Recommendations and Principles for Addressing Electronic Document Production* (Sedona Conference Working Group Series 2007).
3. *Aguilar,* 255 F.R.D. at 354.
4. *Vargas,* 2015 NY Slip Op 31048(U) at **4 (citation omitted).
5. *Aguilar,* 255 F.R.D. at 355.
6. *Vargas,* 2015 NY Slip Op 31048(U) at **4.

aware of the patient's change in status. EMR alone is inadequate and metadata needs to be examined because no actual notes regarding this encounter are reflected in the chart. Metadata may assist to establish the extent of a physician's involvement in treating a patient. Such was the case in a recent Monroe County decision.[7] The court permitted discovery of metadata and reasoned that it is relevant if it will help plaintiff quantify (by indicating who, what, when, etc.) the physician's level of involvement in treating the patient.

Even more recently, in July of 2017, Judge Martin Shulman added another potential obstacle that plaintiff's counsel may face when requesting metadata. He ruled that before directing the disclosure of metadata, a requesting party must also establish how prior record disclosures were inadequate and articulate what additional relevant information can be obtained from the metadata.[8] From defense counsel's standpoint, it is therefore critical to understand our client's metadata and be able to represent to the court how its disclosure will fail to provide any additional relevant evidence. Counsel must demonstrate the sufficiency of the EMR.

EMR Errors v. Metadata

As explained above, the Courts currently intend for metadata to only be disclosed if plaintiff can prove that it is uniquely relevant to the claims. Plaintiff's counsel often attempt to muddy the relevancy of metadata by highlighting how EMR is deficient, missing, altered or otherwise contain errors. Plaintiffs use these issues to create inferences that a physician was careless and argue that metadata is necessary to further explain the discrepancies, errors or changes and prove negligence. The true issue, however, is already apparent and evident from the EMR itself. Plainly speaking, it is a documentation issue – an issue as old as the first paper record. Metadata has never been needed to prove such a claim.

Again, these are not situations in which the courts intend for metadata to be disclosed. EMR and the metadata behind it are two distinct sources of information. It is incumbent on defense counsel to argue that metadata is not relevant to decipher these types of innocent clerical errors that speak for themselves and can be explained by other means such as deposition testimony. This is especially so when the claim is one only of medical negligence. Almost all documentation issues are collateral and not relevant to the malpractice. Therefore, it is essential for defense counsel to be mindful of the specific claims alleged as the relevancy of metadata, or lack thereof, may hinge on them.

While it is important to defend against the unnecessary production of metadata, it is equally crucial to appreciate how metadata may also be advantageous to the defense, and is not something to be protected absolutely from disclosure.

Conclusion

While it is important to defend against the unnecessary production of metadata, it is equally crucial to appreciate how metadata may also be advantageous to the defense, and is not something to be protected absolutely from disclosure. Thought must be given to each discovery response as metadata may prove critical to a physician's defense. In some cases, a physician's knowledge of certain events may only be demonstrated by using metadata and, in those circumstances, there should be a strategic evaluation of proactively disclosing metadata.

Nancy J. Block is a Senior Partner at Martin Clearwater & Bell LLP. Her practice encompasses all aspects of medical malpractice litigation from inception through trial. She has defended some of the Firm's largest hospital clients as well as individual physicians. She has worked extensively in complex multi-party federal and state litigation and is well versed in the requirements of electronic discovery and the preservation of electronically stored information and advises on these issues.

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7. *Gilbert v. Highland Hospital,* 52 Misc.3d 555, 2016 NY Slip Op 26147 (Sup. Ct., Monroe County 2016).
8. *Czyz v. Scherl et al,* 2017 NY Slop Op 31465(U) (Sup. Ct., NY County 2017).

The Use of Health Insurance Experts in the Defense of Future Medical Costs in Brain Injury Cases

By: Anthony M. Sola and Daniel L. Freidlin

Introduction

The successful defense of high exposure medical malpractice cases is partly dependent on the careful selection of experts to analyze issues related to the adequacy of the treatment rendered, causation and damages. While attention is almost always given to the retention of medical experts to evaluate whether the defendant health care provider conformed to the standard of care, the importance of causation and damages experts sometimes goes underappreciated.

Having experts to contest plaintiff's claimed damages is even more critical in cases involving brain injury. These cases typically involve individuals with permanent neurological deficits who claim that they require extensive future medical care. In the typical brain injury case, the plaintiff's attorney will retain experts such as a life care planner to opine that plaintiff requires lifelong treatment including various therapies, monitoring by medical specialists, and individualized 24/7 nursing care to assist with activities of daily living. The life care planner will frequently overinflate the cost for these therapies, using "billed cost" or "market cost", and that number grows even higher after the plaintiff's expert economist applies an unrealistic growth rate to the cost of future medical care. By the time the plaintiff's damages experts are finished "analyzing" the cost, we are left with a number that most often contains seven zeroes or more. And this is only for future medical costs.

Recognizing this significant cost of future medical care in brain injury cases and the resulting exposure to medical malpractice defendants, New York State established the Medical Indemnity Fund (MIF) in 2011. The MIF provides a funding source for future health care costs associated with birth-related[1] neurological injuries. However, the MIF does not cover future medical costs if the neurological injury is not birth related. Thus the future medical costs for a child or an adolescent who sustains a stroke or other brain injury will not be covered by the MIF. In cases where the MIF will not cover the future medical costs, it is essential that defense experts are retained to challenge the plaintiff's often exaggerated claimed future medical costs.

If the case goes to trial, the ability to convince a jury that the plaintiff is exaggerating the costs serves two purposes. First is in the event of an adverse verdict to have evidence in the record to demonstrate to an appellate court that the award was excessive and should be reduced. But the second one is to persuade the jury that the plaintiff is not being honest with them and thus allow an argument that since plaintiff is not honest on damages then the jury should question the validity of the claims regarding departures and causation as well.

A Case Example

Martin Clearwater & Bell LLP recently defended a teaching hospital in a case involving an eighteen year old college student majoring in architecture who sustained a massive stroke during a relatively routine hospitalization. The liability defense was weak at best as there was an approximate twenty hour time period that the hospital residents were documenting the plaintiff's progressive neurological complaints but no workup as to the cause was conducted. It was thus imperative to retain a full roster of damages experts in an effort to limit the plaintiff's potential recovery. In addition to a life care planner, vocational rehabilitation specialist, and economist, an expert in health care costs and insurance was retained to evaluate the cost of future medical care under Medicare and the Affordable Care Act.

As stated above, brain injury cases will involve a claim that the injured party requires lifelong medical treatment and nursing care. The plaintiff's experts will cite "market costs" or "billed values" for this future medical care which are often multiples of the "reasonable value".[2] It has been estimated that less than 5% of national health care payments are made based on "market cost"

1. For the purpose of the Fund, a "birth-related neurological injury" is an injury to the brain or spinal cord as the result of a deprivation of oxygen or mechanical injury that occurred in the course of labor, delivery or resuscitation, or by the provision or non-provision of other medical services during delivery admission that rendered the infant with a permanent and substantial motor impairment or with a developmental disability.
2. The significant difference in these costs can be seen by examining the health insurance carrier's Explanation of Benefits mailed to the patient after a doctor's visit. While the "amount billed" or "market cost" for a routine doctor's visit may be $300, the negotiated rate or "reasonable value" is a fraction of the cost.

or "billed value".[3] Thus, having an expert in health insurance costs becomes crucial to make sure that the cost of care cited by the plaintiff's (or even the defendant's) life care planner is "reasonable". Such an expert can evaluate the cost of care under private health insurance plans (purchased privately or through the Patient Protection and Affordable Care Act) or government funded plans such as Medicare.

Under the Affordable Care Act (ACA), individuals are required to maintain "minimum essential coverage" and insurers cannot deny coverage for individuals with preexisting conditions. Assuming these provisions continue, the plaintiff cannot contend that he will be denied coverage due to their brain injury. In cases where a plaintiff has purchased health insurance under the ACA, we have argued that defendants should be entitled to a collateral source set-off, pursuant to CPLR § 4545(a), for the projected benefits to the plaintiff less the projected cost to the plaintiff of maintaining the coverage. At the very least, where the plaintiff is covered under a government funded plan such as Medicare, the plaintiff should only be entitled to recover the "reasonable value" of future medical care as this furthers the policy of preventing a double recovery and ensuring that an award of damages for future medical expenses corresponds, as closely as possible, to the plaintiff's actual loss.

In our case, our expert prepared a report illustrating that the costs used by the plaintiff's life care planner were inflated by over 30% or approximately $3.5 million. Using the reports prepared by our damages experts, we were able to settle the case for a very reasonable amount. The successful resolution of this otherwise indefensible case was made possible by our careful attention to securing a full roster of damages experts including analysis of the plaintiff's "reasonable cost" of future medical care under the ACA.

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Case Results *Continued from page 3*

involved a then 23 year old female who underwent a Cesarean section after a prolonged labor with several non-reassuring fetal monitoring strips. Following the Cesarean section, the plaintiff suffered a postpartum hemorrhage secondary to uterine atony. Efforts to get the uterus to contract and cease the bleeding were unsuccessful. The plaintiff ultimately became hypotensive despite the use of vasopressors and a hysterectomy was performed. Plaintiff argued at trial that additional efforts and techniques should have been used to contract the uterus and stop the bleeding before performing a hysterectomy on the 23 year old plaintiff. MCB successfully argued that not only would the efforts suggested by plaintiff at trial not have caused the uterus to contract but the plaintiff rapidly decompensated and the hysterectomy performed was lifesaving.

July 2017: Michael A. Sonkin received a defense verdict in Supreme Court, Bronx County before Justice Soto. This case arises out of a right eye cataract extraction with an intraocular lens (IOL) implant performed by the co-defendant ophthalmologist, at the Surgicare Ambulatory Center on March 9, 2011. The plaintiff was a 79 year old African American female. During the procedure, the plaintiff squeezed the speculum in her eye very hard causing her IOL and anterior vitreous to herniate through the pupil and into the anterior chamber. The lens and vitreous were removed from the anterior chamber and an anterior lens was placed. The patient was brought to the recovery room in stable condition and discharged home that day with instructions to follow-up in the clinic in the morning. It is claimed that intraoperative complications was caused by the insured defendants failure to administer sufficient anesthesia during the subject procedure. The jury returned a defense verdict.

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3. George A. Nation III, "Determining the Fair and Reasonable Value of Medical Services, the Affordable Care Act, Government Insurers, Private Insurers and Uninsured Patients," page 456.

MCB NEWS

MCB Congratulates Our Attorneys on Selection to 2018 Best Lawyers

Martin Clearwater & Bell LLP is proud to announce that five MCB Senior Partners that have once again been selected by their peers for inclusion to Best Lawyers in America©

- **Anthony M. Sola** was again selected in the fields of Medical Malpractice Law – Defendants and Personal Injury Litigation – Defendants.
- **Peter T. Crean** was again selected in the fields of Medical Malpractice Law – Defendants, Personal Injury Litigation – Defendants and Legal Malpractice Law – Defendants.
- **Kenneth R. Larywon** was again selected in the field of Health Care Law.
- **Bruce G. Habian** was again selected in the field of Medical Malpractice Law – Defendants, Personal Injury Litigation – Defendants and Legal Malpractice Law – Defendants.
- **John L.A. Lyddane** was again selected in the field of Medical Malpractice Law – Defendants and Personal Injury Litigation – Defendants.

Case Results *Continued from page 7*

July 2017: Justice O'Donoghue granted a Queens County Supreme Court motion for summary judgement in this matter. The motion, which asserted that there was no deviation from the standard of care and no proximate cause of plaintiff's alleged injuries, was argued by Associate **Kathryn R. Baxter**, with Senior Partner **John L.A. Lyddane** and Associate **Zachary D. Olivia** also involved in obtaining this positive result. The matter involved a then 32 year old man who presented to our defendant physician with complaints of hoarseness for the last several years and was diagnosed with a large hemorrhagic vocal cord polyp. Our defendant performed a resection of the laryngeal mass, rigid esophagoscopy, and biopsy utilizing CO2 laser. Post-operatively, the plaintiff reported a dysphonic and strained voice. Defendants moved from summary judgment, which Justice O'Donoghue granted in its entirety, finding that plaintiffs' expert's opinions were speculative in nature, that plaintiffs' expert failed to cite any medical record supporting the opinion that the defendant removed excessive healthy vocal cord tissue resulting in his alleged injuries, and that plaintiffs' expert failed to opine that an alleged injury, a vocal cord divot, which was found to be scarred following the surgery at issue, could have only been scarred if the defendant physician negligently performed the surgery at issue. Consequently, Justice O'Donoghue found that plaintiffs' expert affidavit failed to raise a question of fact sufficient to defeat defendant's motion for summary judgment.

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