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Health Care Law
MARCH 2016

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One Size Fits None
Whether Practicing Medicine or Law, Tailoring is a Must

By now, we all have read about doctors across our state and the entire country who have been found to have operated “pill mills,” or offices that provided prescriptions for narcotic pain medications on flimsy or no evidence of need. Some have gone to jail; some have lost their medical licenses; all who participated in this scheme are treated with scorn and anger by the true professionals who work to help their patients, not to hook them.

It might surprise you to know that I can imagine how a doctor might start down that slope without specifically intending harm. Doctors today are expected to see more patients in a day than twenty or thirty years ago. With ten minutes or less to review a chart, listen to the patient, diagnose, offer advice and then make chart notes (without which the doctor does not get paid), how challenging is it to look at a patient who claims his or her pain is no better than last month, and not repeat the prescription for pain pills? The best doctors do not give in; some human ones — as well as the uncaring ones — do.

There is no precise analog in our profession, but there are some situations that can be similar. Recycling documents, “boilerplate,” and other efforts to save our clients money and ourselves the time, worry and the effort of recreating relatively common language can in fact save time, money and effort with little if any downside. But if we rely too much on labor-saving document libraries or citation blocks, we can find ourselves farther down a dark road than we ever planned. I can’t speak to what transactional attorneys might see, but as a litigator, I certainly have been on the receiving end of such work. Have you?

How many times have you received documents seeking discovery from your client, and the pronouns are all over the board, and even a wrong name or two shows up? Have you ever received a deposition notice in a case that is not yours, because the attorney recycling the deposition notice neglected to change the certificate of service? How about a motion to dismiss carrying a paragraph replete with detailed, pin-point cited yet recently-overturned caselaw in support of the argument? I have seen all of these. We all are human, of course, and human error is inevitable. But my experience is that the attorneys who make these errors more than once go on to make them over and over again.

The larger question in both professions is this: where is the line between error and choice? At what point can we look at the doctor practicing out of a pain clinic and say that she has chosen to violate medicine’s first principle: do no harm? And at what point can we look at the attorney filing the umpteenth iteration of a motion and say that he has moved from making minor, non-culpable errors to culpable malpractice?

I don’t know.

It feels to me as though the question each of us must ask, every time we take action on behalf of a client, is “Do I believe, after inquiry and analysis, that doing this will properly advance my client’s interests and not conflict with my duties to the court?” If the answer is “yes,” then sign and send it. If the answer is “no,” then think some more.

Medicine and law are two of the three ancient “learned professions” (the third is the clergy). These professions have been set apart from others for centuries because of the potential for practitioners in each of them to do great harm, as well as great good. Irrespective of short-sighted decisions by some doctors and some lawyers, let us all remember and take as our first precept the baseline rule of medicine: do no harm.
MUSSETTE VINCENT

Firm/Company: Jackson Lewis P.C.
Title: Of Counsel
College: Smith College
Law School: Case Western Reserve University
CMBA Join Date: 1982

TELL US ABOUT YOUR FIRST JOB?
I worked behind the steam table at the Hot Shoppe, a cafeteria-style restaurant. Let’s just say it reinforced my intention to finish college.

WHAT DO YOU DO FOR FUN?
Play duplicate bridge, bake pies, and rock out with The OldKids (a rock cover band).

WHY DID YOU BECOME A LAWYER?
My family often told me I should be a lawyer because I was so argumentative. When I was eleven or so I ran out of books in the children’s section so my mom got me a regular library card and the first book the librarian suggested for me was The Defense Never Rests by F. Lee Bailey. It was part autobiography and part inside story of the famous Cleveland murder trial of Dr. Sam Shepard. Then I read The Coine Mutiny. After that I don’t think I ever gave serious thought to doing anything else.

IN WHAT CITY DO YOU LIVE, AND WHAT DO YOU LIKE ABOUT IT?
Bratenahl. It is a true village, complete with ice cream socials, wonderful green space, the best fireworks in the county and friendly and helpful police, and where strangers freely introduce themselves and are strangers no longer.

WHAT’S THE BEST PART ABOUT BEING A LAWYER?
All the great stories! And the worst part is that you can’t repeat any of them!

GABRIELLE T. KELLY

Firm/Company: Brouse McDowell LPA
Title: Partner
College: Boston University
Law School: Case Western Reserve University
CMBA Join Date: 2008

WHAT DO YOU LOVE ABOUT YOUR JOB?
I love reading an insurance policy that seems complicated and determining which provisions are relevant to a coverage dispute.

WHAT WAS YOUR FIRST PET?
I had a black Lab named Cookie. I really wanted a pony, so I would climb on Cookie’s back and make her walk me around the dining room table. Cookie would growl whenever my parents tried to take me off of her back.

WHY DID YOU JOIN THE CMBA?
I joined the CMBA to meet other attorneys and become involved in the Cleveland legal community. The CMBA continues to help me accomplish these goals.

DESCRIBE AN IDEAL SUNDAY.
An ideal Sunday starts by lounging around listening to music, and then watching a baseball game outdoors in the afternoon.

WHAT’S ON YOUR BUCKET LIST?
I really want to visit all 50 states; I have about 11 left!

KRIS WISNIESKI

Company: CMBA
Title: Development Assistant
CMBA Start Date: September 2011

IF YOU WERE NOT IN YOUR CURRENT PROFESSION, WHAT WOULD YOU BE?
Travel Journalist for the Travel Channel. I love to travel and experience new things and the idea of getting paid to visit new countries and eat exotic foods is exciting to me.

TELL US ABOUT YOUR PETS.
We have two dogs, Bella and Honey. Honey is a rescue. She’s a lab, greyhound mix. Bella is a shepherd, border collie, beagle mix. I have always had a dog since I was young and would be lost without one.

TELL US ABOUT YOUR KIDS.
We have two children, Jake and Taylor. Jake is 25 and is a University of Cincinnati graduate, and is currently working on his Masters degree in Mental Health Counseling at Xavier University. Taylor is 23 and graduated from Ohio University and works for Brand Muscle, a marketing firm in downtown Cleveland.

WHO HAS INFLUENCED YOU THE MOST IN LIFE?
My parents. They taught me to be caring, courteous, helpful and treat others with respect.

WHAT WOULD REALLY SURPRISE PEOPLE ABOUT YOU?
I was adopted when I was 3 days old and my birth mother was related to my adopted mother by marriage. My brothers and sisters contacted me 23 years ago, and we’ve been a family ever since. I am so blessed to have such a loving and caring family.

INTERESTED IN BEING FEATURED OR KNOW SOMEONE WHO MIGHT?
E-mail Jackie Baraona at: jbaraona@clemetrobar.org.
HEALTH CARE LEGISLATIVE UPDATE:
Winds of Change Impact Mid-Level Providers

Significant Differences Remain Between Physician Assistants and Nurse Practitioners

BY ISABELLE BIBET-KALINYAK

On the footsteps of major federal regulations published under the Affordable Care Act, Ohio legislators crafted significant amendments to Ohio laws and rules governing the practice of Physician Assistants (PAs) and Advanced Practice Registered Nurses (APRNs). These seemingly benign updates continue to add layers of complexity and risk in the health care system.

Although commonly referred to collectively as mid-level providers, non-physician providers (NPPs), or physician extenders, PAs and APRNs represent two discrete professions that fall under the jurisdiction of separate regulating bodies, the State Medical Board (the “Board) and the Board of Nursing respectively. PAs and APRNs must comply with separate laws and regulations in terms of education, training, licensing, scope of practice, prescriptive authority, physician supervision/collaboration, professional liability, and billing. Health care providers should carefully monitor legislative changes and assess compliance separately for PAs and APRNs. As the market for NPPs heats up amidst a primary care physician shortage, employers who best understand similarities and differences between PAs and APRNs will be able to strategically staff and retain NPPs to best fit their needs and budgets.

Senate Bill 110, Effective October 15, 2015

The most significant piece of legislation affecting NPPs is Senate Bill 110 (S.B. 110” or the “Bill). Signed into law by Governor Kasich on July 16, 2015 and effective as of October 15, 2015, the Bill enacts five new sections of the Ohio Revised Code, repeals over a dozen sections, and amends not less than fifty other sections. The two most important aspects of S.B. 110 are the modernization of Chapter 4730 of the Ohio Revised Code, which governs all PAs, and the new delegation rules for PAs and NPs with prescriptive authority. NPPs, employers, hospitals, and payors should closely follow these developments to avoid any potential issues with billing, credentialing, and risk management. Further, industry stakeholders such as laboratories, hospitals, physicians, and payors should take notice that S.B. 110 does not only affect NPPs: it contains the following elements: a description of the physician’s responsibilities; a description of any alternate supervising physicians the supervising physician desires to designate. The physician is liable for maintaining the supervision agreement and may face a civil penalty of up to $1,000 for non-compliance. If the PA practices in a health care facility, the supervising agreement must stipulate that the PA is to comply with all facility policies. PAs practicing outside health care facilities no longer have to file a Board-approved supervisory plan; the supervision agreement suffices, provided it contains the following elements: a description of the physician’s responsibilities; a description of the PAs responsibilities when performing services under the supervising physician and any limitations thereof; circumstances requiring the PA to refer a patient to the supervising physician; and the names, business addresses, and telephone numbers of any alternate supervising physicians the supervising physician desires to designate.

Physician Assistants – Chapter 4730, A Momentous Makeover

Ohio laws pertaining to PAs received a major facelift with S.B. 110. The changes are broad and detailed – employers and facilities should examine all sections of Chapter 4730 and immediately update their credentialing processes. Some of the most impactful changes under S.B. 110 affect PAs’ autonomy. Although PAs must continue to work under the supervision of a physician(s), supervising physicians no longer have to regularly review the condition of patients treated by PAs. PAs no longer have to clearly identify the supervising physician on medical orders.

Supervising physicians must still file a supervision agreement with the Board but such filing is free and automatically takes effect on the fifth day after submission unless the Board notifies the supervising physician that the agreement is defective. Once in effect, the supervision agreement is valid for two years, unless amended or rescinded by the supervising physician. Physicians may supervise up to three PAs (up from two). The physician is liable for maintaining the supervision agreement and may face a civil penalty of up to $1,000 for non-compliance. If the PA practices in a health care facility, the supervising agreement must stipulate that the PA is to comply with all facility policies. PAs practicing outside health care facilities no longer have to file a Board-approved supervisory plan; the supervision agreement suffices, provided it contains the following elements: a description of the physician’s responsibilities; a description of the PAs responsibilities when performing services under the supervising physician and any limitations thereof; circumstances requiring the PA to refer a patient to the supervising physician; and the names, business addresses, and telephone numbers of any alternate supervising physicians the supervising physician desires to designate.

S.B. 110 replaces the PAs’ certificate to practice with a license and eliminates the...
Certificate to prescribe in favor of a prescriber number issued by the State Medical Board. PAs with a valid prescriber number may exercise physician-delegated prescriptive authority, with one limitation: the physician must exercise on-site supervision for the first 500 hours, unless the PA practiced with prescriptive authority in another jurisdiction for at least 1,000 hours. The supervising physician is liable for maintaining logs and records of the supervised hours.

Mid-Level Providers – Variations in Scope of Practice

Employers and facilities should ensure they understand the scope of practice of each NPP. Failure to properly delineate the NPP’s scope of practice may trigger licensing issues for the NPP, as well as accreditation, billing, and liability problems for the employer or facility. For instance, an employer may have to self-disclose and repay Medicaid if an NPP provided services to young children but was only authorized to see adults and adolescents.

The range of services PAs and APRNs respectively provide considerably overlaps. Yet, direct comparisons of their scope of practice are difficult and risky, in part due to differences in educational background, training, licensing, and specializations, but mainly due to the foundational philosophies behind each of the professions. PAs are medical professionals who always work under the supervision of one or several physicians. They are by nature physician extenders. APRNs on the other hand merely collaborate with one or several physicians. They are Registered Nurses (RNs) with a master’s degree or doctorate in advanced practice nursing who can work and bill independently from physicians. Unlike PAs, APRNs can be self-employed.

S.B. 110 revamps the scope of practice of PAs. They can perform a pre-defined list of services if such services are part of the normal course of practice and expertise of their supervising physician: (1) ordering diagnostic, therapeutic, and other medical services; (2) prescribing physical therapy or occupational therapy, or referring a patient to a physical therapist or occupational therapist; (3) taking any action that may be taken by an attending physician regarding Do-Not Resuscitate (DNR) Identification and Orders; (4) determining and pronouncing death; (5) assisting in surgery; (6) ordering, prescribing, personally furnishing, and administering drugs and medical devices if the PA has physician-delegated prescriptive authority; (7) administering local anesthesia; (8) delegating tasks to implement a patient’s plan of care if certain conditions are met; (9) delegating drug administration; (10) ordering and supervising respiratory care; and (11)
performing any other services that are part of the supervising physician's normal course of practice and expertise — a convenient "catch-all" category, which significantly broadens the scope of services PAs may perform and eliminates the requirement to obtain Board approval to provide services not specifically listed.

S.B. 110 does not affect the scope of practice of APRNs. Unlike with PAs, Ohio law does not list the services APRNs may perform but rather places the burden on APRNs and employers to determine whether a service falls within the scope of practice based on education, certification, training, experience, and the standard care arrangement with the collaborating physician(s).

New Delegation Rules for Certain Tasks and Medication Administration.

S.B. 110 significantly broadens the delegation powers of NPPs. The Bill allows PAs to delegate tasks to implement a patient's plan of care to any person, including unlicensed individuals, if the following three conditions apply: the PA is physically present onsite; the task is appropriate for the patient; and the person to whom the delegation is to be made may safely perform the task.

Liability of Supervising Physicians – PAs Only

S.B. 110 adds PAs to the list of individuals who may direct a Licensed Practical Nurse (LPN) to perform nursing care. This noteworthy addition allows PAs to direct LPNs to administer IV therapy, a privilege previously reserved to physicians, dentists, optometrists, podiatrists, and RNs.

Further, S.B. 110 allows PAs with prescriptive authority to delegate drug administration to any person, including unlicensed individuals, in outpatient non-emergency settings, if the above three conditions are met and the drug is listed on the State formulary, is not a controlled substance, and will not be administered intravenously (See R.C. 4730.203). The Bill provides similar delegation authority to APRNs with prescriptive authority under certain conditions (See R.C. 4723.48).

Isabelle Bibet-Kalinyak, J.D., MBA, is a corporate health care and immigration attorney with extensive business experience. She is a member of the Health Care, Corporate, and Labor & Employment practices of the full-service law firm of Brouse McDowell. She joined the CMBA in 2015. She can be reached at (330) 535-5711 or IBK@Brouse.com.
9th ANNUAL MEETING

Campaigning for Cleveland

Friday, June 3rd

WE WANT YOU TO SAVE THE DATE

Ramp up for the 2016–2017 Bar year and the RNC!

FirstMerit Convention Center of Cleveland

Doors open at 11 a.m. ★ Lunch at 11:45 a.m.

Join us for the installation of the 2016–2017 CMBA President Richard D. Manoloff of Squire Patton Boggs and our new officers and trustees. In addition, we will celebrate the newest class of 50- and 65-year Honorary Life Members and the recipients of this year’s Association awards.

NEW IN 2016 EXPO

Meet CMBA Section, Committee, and Program leaders as well as Cleveland businesses to learn about opportunities for engagement, volunteering, and business development.

Registration to follow. Visit CleMetroBar.org for updates.
In October, the Diversity and Inclusion Committee launched a comprehensive survey initiative to collect data about the practice of law in the Greater Cleveland area. The first step involved a Phase I Survey mailed to 748 law firms, corporate legal departments, courts and other public sector entities seeking demographic data and statistics regarding the attorneys and other legal professionals each employs. In addition, the survey asked a series of narrative questions designed to glean specific information regarding diversity and inclusion efforts that are working across greater Cleveland.

A Phase II survey launched in mid-February. It involves the collection of data from nearly 9,000 individual lawyers, paralegals and other legal professionals. Unlike the objective nature of the data collected from the Phase I, employer-targeted survey, the Phase II survey takes a deeper dive into individual experiences of lawyers and legal professionals, including a variety of questions related to advancement and compensation, career satisfaction, mentoring, office culture and inclusion.

Both of these surveys were developed so that we, the legal community, could collect reliable data that can tell us where our legal community stands today. By collecting this benchmark data, we will be able to assess where we are as compared to where we have been (although some of the data has not previously been collected), to other communities and to the national picture. Understanding where we are will help us collectively create a plan for where we want our legal community to go.

As of the date I am writing this article, the Phase II survey is still open, but all of the data from the Phase I employer survey has been received. We succeeded in collecting a significant amount of information from 148 of the 748 different organizations that were invited to participate. That represents a 20% response rate — a stronger showing than the typical 10–15% response rate for external surveys.

Once all the data has been collected and analyzed under the leadership of Majeed Makhlouf, our VP of Diversity and Inclusion, and the entire Diversity and Inclusion Committee, we will issue a detailed report of the findings. (As we represented from the outset, all data will be reported in aggregate form. No individually identifying information will be released absent written consent.) The release of that report will occur in conjunction with a Diversity Conference planned for May 20 at the CMBA. In addition to discussing our benchmark data, we will be joined by Vernä Myers, a nationally recognized speaker who will facilitate a discussion about the role unconscious bias plays in preventing genuine workplace inclusion.

For now, as the drafting of our report kicks into high gear, I wanted to take a moment to personally congratulate and to thank each law firm, corporation, court and agency listed below that responded to the Phase I survey. I applaud your leadership and your commitment to this profoundly important endeavor. We invite you — as well as every other member of our legal community — to meet us at the Bar on May 20 so we can continue our collaboration in building a stronger, more inclusive profession.

Abel & Zocolo, LPA
Bonezzi Switzer Murphy Polito & Hupp Co. L.P.A.
Buckley King
Calfee, Halter & Griswold LLP
Cavitch, Familo & Durkin Co., LPA
Chernett Wasserman LLC
Cleveland Clinic Law Department
Cleveland Metroparks
Cleveland State University
Coakley & Lammert Co., LPA
Cuyahoga County Common Pleas Court
Cuyahoga County Department of Law
Cuyahoga County Domestic Relations Court
Cuyahoga County Inspector General
Cuyahoga County Juvenile Court
Cleveland Municipal Court
Cuyahoga County Prosecutor’s Office
Cuyahoga County Public Defender’s Office
Dickie, McCamey, & Chilcote, P.C.
Douglass & Associates Co.
Eaton Corporation
Euclid Municipal Court
Fay Sharpe LLP
Fanger & Associates
Felt & Lembright
Fisher & Phillips
Forest City Enterprises
Frantz Ward LLP
Friedman, Domiano & Smith Co., LPA
Gallagher Sharp
Garfield Heights Municipal Court
Giffen & Kaminski, LLC
Greater Cleveland Regional Transit Authority
Hahn Loeser & Parks LLP
Harvey, Abens, Losue Co., LPA
Hickman & Lowder Co., LPA
Hurtuk & Daroff Co., LLP
Ice Miller LLP
Berns, Ockner & Greenberger LLC
Brenesh, Friedlander, Coplan & Aronoff LLP
Brentoff & Spero Co., LPA
From the Executive Director

Rebecca Ruppert McMahon

Oh, The Places We Can Go ... Together
did your miss having your ad or listing in the 2015 legal directory?

Increase your firm and peer referrals in 2016 and 2017 by making sure your firm or company is listed in the...

2016–2017 LEGAL DIRECTORY!

The CMBA’s hardcopy and electronic Legal Directory is the most efficient way to advertise your law firm or legal products and services to Northeast Ohio’s top law firms and attorneys. Attorneys and other legal professionals use the Directory on a daily basis, making your ad work every day of the year.

If interested, please contact either advertising rep:
Chris Allen at (216) 736-8601 or cpublishing@me.com
John Moore at (216) 721-4300 or jmoore@lpcpub.com

Deadline for advertising is June 10, 2016!

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Rebecca Ruppert McMahon is the Executive Director of the CMBA and the CMBF. She has been a CMBA member since 1995. She can be reached at (216) 696-3525 or rmcmahon@clemetrobar.org.
**Volunteer Lawyers for the Arts Committee (VLA)**

**Chair**
Jaclyn Matayoshi Vary  
Schneider Smeltz Spieth Bell, LLP  
jvary@sssb-law.com

**Staff Liaison**
Jessica Paine  
jpaine@clemetrobar.org

**What is your goal?**
The VLA's mission is to facilitate access to legal services for local artists and arts organizations, through pro bono help and free public education; to help build a living network of the region’s lawyers and artists; and to advocate for a strong and vibrant arts community.

**What Can Members Expect?**
At our monthly meetings, members enjoy the camaraderie of other artistically-inclined attorneys and in-the-know community members. Every month we review 2–3 applications for pro bono legal assistance for potential acceptance and referral to VLA members. We plan upcoming events in the community, looking to educate the public on the law as it relates to the arts and to connect with all of the fascinating and unique arts locales our city has to offer. We end our meetings with an update on upcoming arts-related events in the Greater Cleveland area, with the goal of supporting the local artistic community.

**Upcoming Events**
VLA members are speaking at two upcoming CLE events in partnership with the Reach Out for Nonprofits program of the CMBA, the Federal Bar, and the ACC of Northern Ohio: Nonprofit Formation with speaker Steve Day on April 7 and Employment Law for Nonprofits: How to Reduce Risk and Improve Compliance with speaker Meredith Shoop on August 25. Our annual Summer Social is a fun event for those interested in getting to know us better and to enjoy one-of-a-kind access to Cleveland’s first-rate arts venues. This summer we hope to feature a performance by a former-VLA applicant — save the date for June 11!

**Recent Event**
The VLA has been busy over the fall and winter with free public presentations and CLE seminars. VLA speakers have presented on contract law at the Cleveland Institute of Art as well as on estate planning for the artist at the Artists Archives of the Western Reserve. Additionally, the VLA staffed a Brief Advice Clinic with Legal Aid at El Barrio during Pro Bono Week and extended our partnership with Reach Out through a reprise presentation of our very popular program on planning legally compliant events.

**Health Care Law Section**

**Chair**
W. Clifford Mull  
Benesch, Friedlander, Coplan & Aronoff LLP  
cmul@beneschlaw.com

**Other Officers**
Laura McBride, Metro Health System, Vice-Chair  
Ryan Williams, Brouse McDowell LPA, Treasurer  
Victoria Vance, Tucker Ellis LLP, Secretary

**What is your Goal?**
To provide educational and networking events for health law attorneys in northeast Ohio.

**What Can Members Expect?**
Quarterly CLE and twice yearly networking events

**Event**
Medical Legal Summit held on March 11–12, 2016

**Lawyer-Client Fee Dispute Resolution Committee**

**Chair**
Lee A. Koosed  
Stotter & Koosed  
StotterK@aol.com

**Vice Chair**
Matthew P. Moriarty  
Tucker Ellis LLP  
matthew.moriarty@tuckerellis.com

**Staff Liaison**
Heather Zirke  
hzirke@clemetrobar.org

**What is your goal?**
To provide lawyers and their clients a prompt, fair, convenient and effective method of resolving fee disputes.

**What can members expect?**
Being an arbitrator is a great service to both the members of the Bar and the community. It is a way to inject a neutral into a dispute at low cost and relative convenience, and demonstrates to all the participants another way in which the CMBA provides value. Further, it is a way for Committee members to see the kinds of disputes that can arise and learn how to avoid fee disputes in the first place. Arbitration hearings are held at the CMBA Conference Center. If the amount of the dispute is over $2,000, the panel consists of three arbitrators — one attorney member and two lay members. If the amount of the dispute is under $2,000, there may be one attorney arbitrator.

**Recent Event**
Best Practices for Lawyer-Client Fee Dispute Arbitrations was held on November 9, 2015.

**Section and Committee membership is a great way to get plugged in at your local Bar!**
For information on how to join a section or committee, contact Samantha Pringle, Director of CLE and Sections, at:
(216) 696-3525 x 208 or springle@clemetrobar.org.
Protecting the Provider-Based Status of Your Satellite Outpatient Clinics

BY MICHAEL VANBUREN & DAVID E. SCHWEIGHOFER

Hospitals and health systems have increasingly availed themselves of the ability to treat a facility located off of the hospital’s campus as a part of the main hospital facility for purposes of billing Medicare (and often private payors) by obtaining “provider-based” status for those off-campus sites. These off-campus provider-based departments may be outpatient surgical centers or may be clinics staffed by physicians providing professional outpatient services. Provider-based status allows the hospital to bill a facility fee for the services under the Hospital Outpatient Prospective Payment System (OPPS) in addition to the applicable professional provider fees. This substantially increases the hospital’s reimbursement collections from billing only a professional fee or from billing under the ambulatory surgery center (ASC) fee schedule.

Of course, hospitals incur significant expenses in achieving the level of integration required by the Centers for Medicare & Medicaid Services (CMS) to obtain provider-based status. Nonetheless, hospitals rely on the revenue generated from billing for these off-campus services under OPPS.

Hospitals’ financial dependence on provider-based billings and the existence of off-campus provider-based departments are a perennial source of concern for the Medicare Payment Advisory Commission (MedPAC) — CMS’ legislative activities arm. MedPAC perennially encourages Congress to revisit off-campus provider-based billing as a means of controlling federal health care spending. This concern is part of a larger Medicare trend of moving toward “site-neutral” reimbursement — reimbursement for services that remains the same regardless of the setting in which the services are provided. CMS’ Regional Offices have also been taking a hard look at attestations for new off-campus provider-based departments and changes in current facilities.

**Moratorium on New Provider-Based Clinics**

Medicare’s concerns and activities have culminated in a moratorium on “new” off-campus provider-based departments. This moratorium went into effect on November 2, 2015, as part of the 2015 Balanced Budget Act. (On-campus provider-based departments are exempt as are off-campus emergency departments.) Off-campus facilities participating in provider-based billing prior to November 2, 2015 are exempt from this moratorium (Existing Locations). Any off-campus departments that begin billing Medicare on or after November 2, 2015 will only be able to bill Medicare under OPPS through December 31, 2016 (New Locations). New Locations will cease provider-based billing on January 1, 2017.

Because of the heavy reliance on the revenue from provider-based billing and because many hospitals are in the process of constructing or setting up new off-campus clinics, the American Hospital Association and other groups are aggressively lobbying Congress to rescind the moratorium. To date, Congress has not yet acted on this issue.

**Potential Future Reduction in Reimbursement to Existing Provider-Based Clinics**

Hospitals with Existing Locations should not get too comfortable, however. As of January 1, 2016, CMS is requiring existing off-campus outpatient departments to bill charges using a “-PO” modifier. CMS’ intent is to use this as a means to collect data on the cost of patients obtaining these services in a hospital outpatient department as compared to a physician office, ambulatory surgery center, or other freestanding facility. The likely ultimate outcome of this data gathering will be a decision by CMS to reduce reimbursement to make off-campus department payments site-neutral: payments for these sites of services would be in line with reimbursement for physician office, ASC, and other free-standing sites.

**What To Do in the Meantime — New Provider-Based Clinics**

Hospitals in the process of establishing new off-campus clinics and which were unable to bill under the OPPS for services prior to November 2, 2015 should not necessarily panic yet. Hospital groups are continuing to lobby Congress on the difficulties that the moratorium presents. More immediately, affected hospitals should conduct the necessary financial analysis to quantify what the actual difference would be between billing under the OPPS and billing under the physician and ASC fee schedules (assuming an off-campus site will include an outpatient surgery center). The reimbursement for professional services performed in an off-campus provider-based department is usually significantly less...
than the reimbursement for professional services rendered in a physician office. Similarly, the difference between global payment received for services in an off-campus provider-based department and an ASC may be less than expected, especially when factoring in commercial payor reimbursement. (However, hospitals should note that not all services covered under OPPS are necessarily covered under these other systems.)

Bearing in mind that on-campus provider-based billing is unaffected by the moratorium, the financial impact of the moratorium — while doubtless substantial — may be less significant than initially feared. The hospital can then make a determination regarding converting its off-campus clinic plans to a medical office and outpatient surgery facility.

What to do in the Meantime — Protecting Your Existing Provider-Based Status
Hospitals with off-campus provider-based departments have been experiencing increased scrutiny from CMS, often triggered by a change in location or a survey. CMS has been focusing its scrutiny on two issues — potential shared space arrangements and compliance with patient notification requirements.

Both of these concerns relate to the requirement, found at 42 C.F.R. 413.65(d) (4), that the off-campus provider-based departments be held out to Medicare patients as a part of the main provider (so that the patients are aware that they will be billed as hospital patients, not physician office patients). Off-campus departments that co-mingle space with non-hospital providers can run afoul of this requirement. Similarly, off-campus clinics that fail to maintain signage clearly indicating that the patient is entering a hospital department — often because the off-campus department is located adjacent to or within another hospital facility — can endanger their provider based status.

Hospitals with Existing Locations should conduct walk-throughs of their space to ensure that patients entering the space will understand, based on the signage, that they are entering a hospital department. The signage should be consistent with the hospital’s website, social media accounts, advertising materials, and mailings. These hospitals should
also take the time to review their location and leasing arrangements for potentially inappropriate shared space arrangements. Each CMS Regional Office has a slightly different interpretation on what constitutes shared space; however, the best practice is to avoid shared suites and other types of co-mingled space.

Expanding an Existing Clinic or Moving to a New Location
CMS has not yet promulgated regulatory guidance on the practical issues presented by the moratorium. CMS has indicated that it will publish proposed regulations sometime in 2016. CMS may opt to publish the proposed regulations in the late spring; however, it may wait until the fall and include them in the proposed 2017 OPPS rules.

In the meantime, hospitals with Existing Locations must carefully examine possible Existing Location expansions and moves. Because off-campus provider-based departments enroll with CMS at a particular location, many providers are viewing an increase in space or an expansion of services in the same suite or at the same address as permissible and not as an action that would endanger the Existing Location’s provider-based status. In other words, the same clinic would continue to bill as it did prior to November 2, 2015. Given the consequences of a loss of provider-based status and the expectation of regulatory guidance becoming available later this year, though, it may be prudent to wait on any contemplated expansions.

Also unclear is how CMS will view a change in location of an Existing Location, i.e., leaving the current location and moving the clinic to a new building or suite. Such a move would not result in the main provider adding an additional outpatient clinic and the hospital’s number of provider-based departments would remain the same. The hospital would simply submit a change of information to the Medicare intermediary.

CMS, however, could take the position that a new address indicates a new department. This seems harsh as it would mean clinics could not relocate despite practical reasons for doing so, such as a more convenient location for patients or a more favorable lease rate. But if CMS adopts a strict interpretation of the statutory moratorium, clinic relocations could certainly lead to a loss of provider-based status. Given that CMS has indicated that it is working on proposed regulations, it would be prudent for hospitals to maintain their Existing Locations in their current locations if at all practicable.

Michael VanBuren is a partner with Brouse McDowell and concentrates his practice in the area of health care law, representing non-profit hospitals, specialty hospitals, health systems, long-term care facilities, dialysis facilities, physician groups, and physicians in private practice in corporate, business, and regulatory matters. He has been a CMBA member since 2008. He can be reached at mvanburen@brouse.com.

David Schweighoefer is a partner with Brouse McDowell and represents and counsels health care providers regarding regulatory and corporate compliance, HIPAA, ZPIC and RAC appeals, informed consent matters, and provider transactions. He has been a CMBA member since 2004. He can be reached at dschweighoefer@brouse.com.

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The Family Law Section Presents

**Children Who Reject Their Parents**

State of the Art Solutions for Judges & Attorneys

**Tuesday, April 5**

**REGISTRATION** 8:30 a.m.

**SEMINAR** 9 a.m. – 4:45 p.m.

**CREDITS** 6.25 CLE

CEU requested & 6.25 CE approved

**What Is (and Isn’t) Parental Alienation?**

Development of the Dynamic of Parental Alienation; Impact on the Parent(s) and Child(ren) and Courts; GALs, Therapists and Custody Evaluators: Understanding and Dealing with Parental Alienation

**Providing the Differential Diagnosis in Court**

Development of the Case: Preparing for Testimony and Evidence: Introduction and Admission

**Cross Examination of the Mental Health Expert**

Understanding the Issues; Effective Questioning; Admissibility Issues and Qualifying the Expert

**Therapy: Is It a Panacea?**

When is therapy indicated or contraindicated; Protective Separations and Treatment plans and options

**The Role of the Judge**

In Camera Interviews; Assisting the Judge in Identifying Parental Alienation and How to Conduct an Interview with the Child

**Court Orders in Parental Alienation Cases**

Best Practices; Suggested Reprimands and Orders

**PAS: Solutions through Education, Awareness and Connections for Professionals**

**PRESENTERS**

Brian Ludmer is an attorney whose practice focuses on cases involving high conflict divorce, denial of access and parental alienation. He has co-authored a book entitled, High Conflict Custody Battle.

Mayor Jill Egizii is the President of the Parental Alienation Awareness Organization USA. She hosts a radio and television show entitled Family Matters with retired Judge Michele Lowrance.

Sandra McMullin, MA, PCC-SNCC is the Clinical Director of We Care Counseling. She has extensive experience with attachment disorders, anxiety and family matters.

The Real Estate Law Section Presents

**Residential and Commercial Leasing**

**What Is In Your Lease?**

**Thursday, April 14**

**REGISTRATION & LUNCH** 12 p.m.

**SEMINAR** 1 – 4:30 p.m.

**CREDITS** 3.00 CLE requested

**General Overview of Leasing and Discussion of Residential Leases**

- Common Lease Terms and Why They Matter
- Premises Liability — Who is Responsible for What?
- Landlord-Tenant Disputes — How to Best Represent your Client
- Breach of the Lease and Remedies
- Insurance for Landlord and Tenant
- Recording Leases
- How Does the Law Treat Residential Leases Differently?
- Residential Lease Terms to Protect the Landlord
- Residential Lease Terms to Protect the Tenant
- Terms Prohibited in a Residential Lease
- Residential Evictions
- Subsidized Housing

**Commercial Leases**

- Representing the Landlord – What Terms to Always Include in the Lease
- Representing the Tenant – What Terms to Always Demand in the Lease
- Negotiating Tips
- Review of Sample Commercial Lease
- View from the Landlord’s Perspective
- View from the Tenant’s Perspective
- Bankruptcy and the Lease
- Subordination, Nondisturbance and Atornment
- Ground Leases — What Are They and Why Should You Care?
- Leasehold Mortgages — What Are They and Why Should You Care?

**Tenant Purchase Options**

- Land Contract Versus Lease with Option to Purchase — What is the Difference and Why Should You Care?
- Seller-Financed Mortgages – How to Best Represent Your Client

**PRESENTERS**

Amy E. Asseff, McFadden & Freeburg Co., LPA.

Sara M. Donnersbach, Weltman, Weinberg & Reis Co., LPA.

Debora S. Lasch, Singerman, Mills, Desberg & Kauntz Co., LPA.

James M. Doran, Weltman, Weinberg & Reis Co., LPA.
Meet us at the Bar for lunch, networking, and CLE. Check out these one-hour CLEs, sponsored by our Sections.

All programs at held noon at the CMBA Conference Center, unless otherwise noted.

The Labor and Employment Law Section Presents

16th Annual
Northern Ohio Labor & Employment Law Conference

Wednesday & Thursday, April 20 & 21

REGISTRATION 8 a.m.

CONFERENCE 8:30 a.m. – 4:30 p.m. (both days)

CREDITS 13.00 CLE
including 1 Hour Professional Conduct

Wednesday, April 20 – 6.50 CLE

Welcome
Patrick O. Peters, Jackson Lewis P.C.
Lauren C. Tompkins, Giffen & Kaminski, LLC

Mock Mediation of Employment Case
Mediator: Peggy Foley Jones, Giffen & Kaminski, LLC
Defense Attorney: Sarah J. Moore, Fisher & Phillips, LLP
Plaintiff’s Attorney: Ann-Marie Ahern, McCarthy, Lebit, Crystal & Lifman, Co.

Managing the Seismic Shift in the
Upcoming FLSA Exemption Regulations:
What to Expect and How to Handle
Your Employees Under the New Laws
Daniel L. Messeloff, Jackson Lewis P.C.

Ethics of Negotiations for Labor and
Employment Lawyers
Joseph N. Gross, Benesch, Friedland, Coplan and Aronoff, LLP

Lunch Speaker: Work Life Balance
Silke Miller, Personal Success Coach and Life Balance Strategist for High-Achieving Professionals

Arbitration and Class Action Collective
Waivers
John B. Lewis, BakerHostetler LLP

Navigating the eWorkplace: Social Media,
Cyber Security, and Telework
Jonathan T. Hyman, Meyers, Roman, Friedberg & Lewis

Selected Legal Issues and Litigation
Tactics Regarding Restrictive
Employment Covenants
David A. Posner, BakerHostetler LLP

Thursday, April 21 – 6.25 CLE

Public Sector Collective Bargaining
Developments: The Good, the Bad, and the Really Ugly
George S. Crisci, Zashin & Rich

State and Federal Employment Case Law
Update: Cases from the U.S. Supreme
Court, 6th Circuit Court of Appeals,
Ohio Supreme Court, and Ohio Courts
of Appeals
Stuart G. Torch and Christina M. Royer, Elfin, Klinghirm, Royer & Torch, LLC

New Issues within Sex Discrimination
Latha Srivavasan, HR, Compliance, FirstEnergy

Lunch Speaker: From Both Sides Now:
Reflections on Moving from Outside to
Inside Counsel, then Defense to Offense
Betsy Rader, Thoman Petrov Group Co., LPA

Ex-Offender Workforce Re-entry
Kelly Summers Lawrence, Frantz Ward LLP

Overview of the FLSA and Certifying
and Decertifying FLSA Collective Actions
Chasity L. Christy & Lori M. Griffin, The Lazzaro Law Firm, LLC

In House Counsel Panel I: The Pressing
Personnel Issues Keeping You Up at Night
Kerin Lyn Kaminski, Giffen & Kaminski, LLC
(moderator)
Kristin R. Erenburg, Counsel, Cleveland Clinic
Foundation
Rose M. Fini, Chief Legal & Ethics Officer, Cleveland Metroparks
Jennifer Draves, Chief Human Resources Officer &
General Counsel, Eliza Jennings
Michael A. Jackson, Senior Labor and Employment
Counsel, The J.M. Smucker Company
Emily Smyda Kelly, General Counsel & Chief Human
Resource Officer, Visiting Nurse Association of Ohio

In House Panel II: Planning for What Is
Ahead for Employers in 2016
Patrick O. Peters, Jackson Lewis P.C. (moderator)
Mark S. Floyd, Executive Vice President of
Employment DDR, Corp.
Kelly L. Hamilton, Legal Counsel, Labor and
Employment, AmTrust Financial Services, Inc.
Jennifer B. Jackson, Associate Counsel, GCRTA-Legal
Division
Lessie Milton Jones, Assistant General Counsel,
Cleveland, Dominion East Ohio
Paul Mancino, III, Vice President, Assistant General
Counsel & Deputy Compliance Officer, Medical
Mutual of Ohio

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MARCH 2016
Must Misconduct Be Willful to Violate the Ohio Rules of Professional Conduct?

G

ov. Bar R. IV 1 states that the Ohio Rules of Professional Conduct “shall be binding upon all persons admitted to practice law in Ohio. The willful breach of the Rules shall be punished by reprimand, suspension, disbarment, or probation as provided in Gov. Bar R. V.” (Emphasis added.) Does GBR IV 1 mean that only willful breaches are subject to sanction? For the reasons that follow, we think not.

Rule IV cannot be read in isolation. When read in conjunction with the relevant provisions of Rule V, as it must be, Rule IV does indeed subject willful breach to sanction, but the Bar Rule specifically dealing with “Disciplinary Procedure,” GBR V, casts a wider net. The key word throughout Rule V is “misconduct,” which is defined in pertinent part as “any violation by ... an attorney of any provision of the oath of office taken upon admission to the practice of law in this state or any violation of the Ohio Rules of Professional Conduct ... .” GBR V 35(J) (emphasis added). Thus, when Rule V section 12 speaks of the imposition of sanctions for violation of the rules, those sanctions follow from “any” violation of the rules, not just from the willful violations mandated by GBR IV 1. See Rule V 12(A), (I), (J), (K).

The tension existing between the current version of GBRs IV (willful breach) and V (any violation) can be traced to the fact that the language of each was promulgated, not as one unified scheme, but in completely separate enactments. The “willful” language, along with the rest of what is now Rule IV 1, was adopted on December 6, 1929, whereas the broader Rule V definition of misconduct did not come into effect until almost 30 years later, on January 1, 1957. It may be that the 1957 drafters intended the more onerous sanctions (which could now be imposed “if merited”) to be applicable to willful violations, with the new option of “private reprimand” available for nonwillful breaches. But the private reprimand sanction was deleted in amendments effective January 1, 1981, without any further adjustment of the disciplinary scheme. As a result, we are left with (1) mandatory sanctions for willful violation (GBR IV); (2) mandatory sanctions for “any” violation of the rules (GBR V 12(A)), which sanctions are to be imposed, according to GBR V 12 (I) & (K), if “merited.” The failure of the drafters at various stages of the amendment process to notice the disconnect between these different components of the disciplinary machinery has resulted in present-day language that does not mesh smoothly. Obviously, not a seamless “legislative” history.

Our best take on this state of affairs, further supported by the case law cited below, is that both “willful breach” (GBR IV) and “any violation” (GBR V 12(A), 35(J)) are subject to sanction, which sanction must be deemed “merited” if a violation is found. This conclusion is consistent with precedent; so far as we are aware, there is no case decided under the present disciplinary regime in which a violation was found but no sanction imposed. The only other reading (which we think is a bit of a stretch) is that the “if merited” language is a reference to the particular sanction determined to be the appropriate (or “merited”) one in the case presented.

If these provisions cannot be reconciled in the manner suggested above, one is forced to the conclusion that the more detailed and later enacted language of what is now Rule V, despite its troublesome “if merited” phrase, supersedes that of Rule IV and precludes any reading requiring that only willful violations are subject to sanction.

Given the broad definition of misconduct in GBR V, individual rules need to be consulted to determine what scintier, if any, is required. By our count, there are 31 different sections or subdivisions of the Rules of Professional Conduct requiring that a respondent act “knowingly” or “intentionally,” or that she “knows” or “reasonably should have known” not to do what she did.1 There are certain other rules, such as 8.4(b) and 8.4(c), dealing with illegal acts and fraud, where it can be argued that the intent factor is inherent in the nature of the conduct prohibited. All of these, it would seem, should trigger the willful breach command of GBR IV 1. This leaves a substantial number of rules and sections of rules in which there is no stated intent prerequisite. One such is Rule 1.15, dealing with safekeeping client funds and property. A number of decisions make clear that 1.15 violations are subject to sanction irrespective of the intent of the respondent. See, e.g., Cleveland Bar Ass’n v. Snow, 72 Ohio St.3d 409, 650 N.E.2d 888 (1995) (“forgetting” to pay medical providers out of settlement funds and withdrawing those funds “by mistake”).

As the Court held in Office of Disciplinary Counsel v. Lucey, 14 Ohio St.3d 18, 21, 470 N.E.2d 888, 890 (1984), underscoring the seriousness of the ethical breach of misuse of client funds: “This is true whether the attorney’s actions are due to dishonesty or, as was the case herein, ignorance and ineptitude.”

Case law supporting the conclusion that willful misconduct is not an across-the-board requisite is not limited to 1.15 decisions. In Cleveland Bar Ass’n v. Mineff, 73 Ohio St.3d 281, 652 N.E.2d 968 (1995), a minor sanction (reprimand) was imposed for a DR 5-103(B) violation that was stipulated to be “technical and not willful.” Id. at 284. And a more recent decision, Disciplinary Counsel v. McCord, 121
Ohio St.3d 497, 2009-Ohio-1517, 905 N.E.2d 1182, supports the view that willfulness is not a prerequisite to sanctionable conduct, when it notes that “ignorance of the rules is not an excuse for misconduct;” id. at para. 41, and that “the only relevant consideration is whether respondent performed the unethical acts; his subjective intent in doing so does not change the analysis.” Id. at para. 32 (emphasis added). A case arguably pointing in the other direction is Disciplinary Counsel v. Mecklenborg, 139 Ohio St.3d 411, 2014-Ohio-1908, 12 N.E.3d 1166, where the Rule 8.4(c) charge was dismissed because “his conduct did not constitute an intentional act of dishonesty, fraud, deceit, or misrepresentation.” Id. at para. 11. But query whether there is any such thing as an unintentional act of dishonesty, fraud, deceit, or misrepresentation. With Mecklenborg, compare Office of Disciplinary Counsel v. Bell, 15 Ohio St.3d 118, 472 N.E.2d 1069 (1984) (rejecting respondent’s argument that he did not violate DR 1-102(A)(4) (the present version of which is Rule 8.4(c)) because he lacked the intent to defraud; proof of his “intentionally submitting two false accountings to the probate court” was fraudulent conduct. Id. at id. 120).

If the rule in question is one in which willfulness is required, does that mean that the respondent must have (1) intended to take the action taken—a deliberate act—as opposed to one unintended; or (2) is he required in addition to have known that the intended act violated an ethics rule? If, a la McCord, ignorance of the rules is no excuse and if there is a presumption that a lawyer knows the rules and must follow them, then it would follow that, where willfulness in some form is required, any deliberate act constituting misconduct would be a violation, whether or not the lawyer in fact knew that that act was in violation of a rule of conduct. Ohio lawyers have sworn that they have read the rules and have sworn to abide by them. Applicant’s Affidavit for Admission to the Bar; Gov. Bar R. I 8. As the Supreme Court stated in Bar Ass’n of Greater Cleveland v. Rubinstein, 22 Ohio St.3d 212, 213, 490 N.E.2d 584 (1986): “As an attorney licensed to practice law in this state, the respondent was charged with knowledge of all of the Disciplinary Rules ...” This provides further support that the presumption of knowledge rests on solid ground, rendering unnecessary proof by clear and convincing evidence that the respondent knew that the conduct was in breach of rule x; the lawyer is charged with that knowledge when he knowingly committed an act that violates rule x.

Of the 31 segments of the rules that contain the “knowingly, knows or should have known, or intentionally” language, all are amenable to the above presumption analysis, with the possible exception of Rules 1.4(a)(5), 6.5(a)(2), and 8.4(a) and (f). A Rule 1.4(a)(5) violation requires consultation with the client about limitations on the lawyer’s conduct “when the lawyer knows that the client expects assistance not permitted by the Ohio Rules of Professional Conduct” t.e., the lawyer must “know” that the rules do not permit the assistance expected by the client. It can perhaps be argued that this express knowledge requirement supersedes the presumption of knowledge and this language requires clear and convincing evidence that the assistance requested is not permitted by the rules and that the lawyer had “actual knowledge” that it was not permitted by the rules. In like manner, 6.5(a)(2) makes Rule 1.10 applicable “only if the lawyer knows that another lawyer associated with the lawyer in a law firm is disqualified by Rule 1.7 or 1.9(a) with respect to the matter.” Rule 8.4(a) applies to respondents who “knowingly assist ... another” “to violate the Ohio Rules of Professional Conduct,” and 8.4(f) to those who “knowingly assist a judge or judicial officer in conduct that is a violation of the Ohio Rules of Professional Conduct ...”

All of the other rules or subparts of rules included in the n.1 list of 31 should require only that the conduct be deliberate, not unwitting. The remaining rules, those which do not contain an explicit or inherent knowledge or intent requirement, can be violated even in the absence of willful conduct. As GBR V 35(f) states, and as the Court held in McCord, “any violation” of “any provision” of the Rules constitutes “misconduct” for which sanctions can be imposed pursuant to Gov Bar R V 12 — “the only relevant consideration is whether respondent performed the unethical acts; his subjective intent in doing so does not change the analysis.”

Marc L. Swartzbaugh is a retired Jones Day lawyer and Arthur F. Greenbaum is the James W. Shocknessy Professor of Law at The Ohio State University’s Moritz College of Law. Marc and Art are the co-authors of “Ohio Legal Ethics Law Under the Rules of Professional Conduct” available on the Internet on The Ohio State University Knowledge Bank. Marc has been a CMBA member since 1965.
Each month, these pages will be dedicated to highlighting just some of the activities and programs of your Cleveland Metro Bar.

OUR NEW ONLINE HOME

Our brand new website is live! Check it out. We think you will love it! The new site better tells the story of the CMBA and who we serve: legal professionals, the public, and students. The website was transformed with you, our members in mind. Re-designed to be more user friendly, the new CleMetroBar.org allows you to see and update your information and activities at the CMBA, connect with other section/committee members, create a public profile for other members to see, and more. We hope you enjoy the new functionality and auto confirmations for registrations, donations, and many other new features.

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OHIO MOCK TRIAL COMPETITIONS

Special thank you to the more than 80 volunteers who helped with Cuyahoga District and Cuyahoga Regional Competitions. The CMBA, through funding support of the Bar Foundation, hosted 49 teams from 19 high schools at the Cuyahoga District Competition on January 29 at the Justice Center and Cuyahoga County Courthouse. We also extend our most sincere thanks to the judges and staff at both courthouses for their contributions to and support of the Mock Trial Competitions!
LOOKING AHEAD

The coming months will be a busy time at the CMBA. Please put these dates on your calendars.

- **March 31**  CMBA Movie Night
- **April 4**  Annual Bench-Bar Memorial Program at Howard M. Metzenbaum U.S. Courthouse
- **April 20–21**  16th Annual Northern Ohio Employment & Labor Law Conference
- **April 28**  CMBA Movie Night
- **May 6**  Cleveland Mock Trial
- **May 25**  Greet the Judges & GCs members-only reception
- **June 1–2**  William J. O’Neill Bankruptcy Institute
- **June 3**  Annual Meeting at the FirstMerit Cleveland Convention Center
- **June 10**  Great Lakes Symposium at The City Club
- **June 27**  Golf Outing at Westwood Country Club

**Get Engaged through Sponsorship Opportunities**
Sponsorship opportunities exist for many of these upcoming and high-profile events. If your firm/office is interested in gaining visibility through support of these events, please contact the CMBA at (216) 696-3525.

GREAT SPONSORSHIP OPPORTUNITY FOR MEMBERS-ONLY EVENT

Our annual members-only Greet the Judges & GCs reception will be Wednesday, May 25 here at the CMBA. Please plan to join us. Stay tuned to email for full details.

This event is made possible through the generous support of sponsors and is a great opportunity for your firm/office, service providers and others to engage at a fun social event here at the CMBA. We encourage you to considering sponsoring and to pass on any recommendations of potential sponsors.

Contact Sarah Charlton at scharlton@clemetrobar.org for more information.

7th Annual Greet the Judges & GCs
A MEMBERS-ONLY EVENT
Wednesday, May 25th
In Honor and Remembrance of the Lawyers and Judges of Cleveland and Cuyahoga County who passed away between January 1 – December 31, 2015

Monday, April 4th at Noon
in the atrium of the Howard M. Metzenbaum U.S. Courthouse

A memorial program will be held for the following members of the bench and bar who passed away over the past year. Family, friends, colleagues and all lawyers in the Cleveland and Cuyahoga County area are invited to share in this final tribute to honor these men and women.

John F. Albu
John M. Baker
I. Joseph Berger
Edward Randolph Brown
Stephen J. Cahn
Pasquale M. Caticcio
Hon. John E. Corrigan
James Allen Draper
Marvin Drucker
Terrence David Durica
Charles Robert Emrick, Jr.
Hon. John W. Gallagher
E. William Haffke, Jr.
Jacque M. Haines
Herbert J. Hansell
Hon. Leodis Harris
Victor M. Javitch
William A. Johnston
Theodore W. Jones
Stanley S. Keller
Elliott Ray Kelley
William M. Kraus
Charles Rocco Laurie Jr.
James P. M'Andrews II
Michael B. McCord
Kenard McDuffie
Bernice G. Miller
William T. Monroe
William David Moore
Donald L. Otto
Kevin F. Payne
Thomas A. Quintrell
John Joseph Reidy Jr.
Richard H. Sayler
Naoma L. Stewart
Congressman Louis M. Stokes
John L. Warner
R. Mark Wells
Jonathon M. Yarger

For more information, please contact Krista Munger at (216) 696-3525 ext. 2224 or kmunger@clemetrobar.org. The CMBA has made every effort to compile a complete list of the attorneys and judges in Cuyahoga County who have passed away over the past year.
By Valerie H. Propper

When the Affordable Care Act (ACA) came into effect in 2010, hospitals and other health care agencies braced for changes in the way they operated and conducted business. In addition to sweeping changes focused on health and welfare benefits, the ACA through the Internal Revenue Code (IRC) established new requirements for non-profit, 501(c)(3) entities. These new regulatory obligations, established additional requirements surrounding such things as community health needs assessments and financial assistance, billing and collections, and emergency care policies (501(r)). In December 2014, the Internal Revenue Service (IRS) and the Department of Treasury, released the final 501(r) regulations which became effective on or before the first taxable year following December 29, 2015 (Treas. Reg. §1.501(r)-7).

The IRS requires 501(c)(3) entities that “operate one or more hospital facilities (hospital organizations)” to comply with 501(r) (www.irs.gov). A “hospital facility” is an entity required by the state to be registered or licensed as a hospital (Treas. Reg. §1.501(r)-1(17)). A “hospital organization,” can be a stand-alone hospital facility or the owner of one or more hospital facilities (Treas. Reg. §1.501(r)-1(18)). A hospital organization operates a hospital facility where, (1) the employees of the hospital facility are employees of the hospital organization, (2) the hospital organization has engaged a third party to manage the operation of the hospital facility, or (3) where the hospital organization is the “sole member or owner of a disregarded entity that operates the [hospital] facility” (Treas. Reg. § 1.501(r)-1(22)). Although slightly counterintuitive, the mere fact that a hospital facility is a subsidiary of a system wide parent does not mean that the parent is a hospital organization that “operates” the hospital facility. The parent of a health system only operates a hospital organization if it meets the definition of “operates” under 501(r).

In summary, 501(r) requires a hospital organization to meet seven requirements:
1. Conduct a community health needs assessment (CHNA) once every three years beginning in the taxable year following March 23, 2012 (Treas. Reg. §1.501(r)-3);
2. Develop an implementation strategy to address the community health needs identified in the CHNA (including a statement as to why certain community health needs may not be addressed) to be adopted by the fifteenth day of the fifth month of the taxable year following the taxable year the CHNA was completed (Treas. Reg. § 501(r)-3);
3. Develop, adopt, and implement written financial assistance (Treas. Reg. § 1.501(r)-4), billing and collection (Treas. Reg. §1.501(r)-7), and emergency medical care policies (Treas. Reg. §1.501(r)-4);
4. Limit charges to patients who qualify for financial assistance and who receive medically necessary and/or emergency care to the amount generally billed (AGB) as determined using one of two methodologies: Look-Back Method or Prospective Medicare and Medicaid Method (Treas. Reg. §1.501(r)-5);
5. Put in place reasonable efforts to determine whether an individual qualifies for financial assistance under the hospital facility’s financial assistance policy prior to engaging in any extraordinary collection activities (ECA(s)) (Treas. Reg. §1.501(r)-6). An ECA includes, but is not limited to, adverse credit reporting, selling an individual’s debt to another party, or garnishing an individual’s wages (Treas. Reg. §1.501(r)-6(b));
6. Notify individuals of a hospital facility’s intention to engage in ECAs not less than 30 days prior to initiation of the ECA (Treas. Reg. §1.501(r)-6); and
7. If applicable, enter into agreements with collection agencies who engage in ECAs on behalf of the hospital facility, obligating such collections agencies to comply with 501(r) to the extent applicable (Treas. Reg. §1.501(r)-6).

Joint Ventures
In addition to wholly-owned hospital facilities, it is possible that a health system through its hospital organization, has an ownership interest in a joint venture. Under 501(r), a joint venture is an entity treated as partnership for federal tax purposes whose partners share in the profits and losses regardless of ownership percentage (Treas. Reg. § 1.501(r)-1(22)). The hospital organization’s treatment of the revenue derived from the joint venture (i.e. unrelated or related to the tax exempt purpose) could influence compliance requirements. Income derived from joint ventures should be reviewed with an internal or external tax specialist to determine if the treatment of such income impacts 501(r) compliance requirements. Consider reaching out to joint venture partners early; joint venture partners may not be familiar with 501(r) requirements.

Determine Who Needs to Comply
Organizations may spend a significant amount of time trying to determine which entities within their systems are required to comply with 501(r). Time should be focused on analyzing whether each entity is considered a “hospital facility” and, therefore, may or may not be subject to 501(r) regulation. If an entity is not a hospital facility, it is likely the facility is not required to comply with 501(r). If the answer is “yes” consider who operates the hospital facility. This information can help you analyze the reach and risk of a penalty if the hospital facility fails to comply with 501(r).
Physician Practice Groups
Physician practice group compliance with 501(r) is ever evolving and poses additional challenges. Physicians employed directly by a hospital organization operating a hospital facility are required to comply with 501(r) (Treas. Reg. §1.501(r)-1(22)). What about those physicians who are not employed by a hospital organization? Work through whether the practice group is a hospital facility and would have to comply with 501(r) on its own. Consider any contractual obligations in place between the hospital organization and the physician practice group. Are they contractually obligated to comply with all hospital facility’s policies and procedures? Also, consider whether patients could become confused because financial assistance policies between providers may differ.

GET THE RIGHT TEAM IN PLACE
Work to convene a group of senior leaders and educate them on 501(r). Do not underestimate the importance of walking through the 501(r) regulations and penalties with senior leadership. Implementation of 501(r) requires significant resources, time, and effort. Without the support of senior leadership, it may be difficult, if not impossible, to impress upon the hospital facility/hospital organization the importance of complying with these regulations.

Bring together leaders in the Departments of Law, Finance, Treasury, Revenue Cycle/Patient Billing, Patient Access, Tax, Marketing, and any other areas that may need to play a role in getting regulatory requirements in place. Create a 501(r) Steering Committee. Set regular meetings to discuss strategy, ownership, and process. Work backwards from dates of Board meetings to ensure preparedness for policy adoption. The lawyer should function as a member of the team, not necessarily the leader. The lawyer can educate the Steering Committee about 501(r), interpret the regulatory scheme and advise on applicability to the organization, review documents for compliance, and provide general advice on 501(r) implementation. The lawyer however, should not be in charge of the implementation process. The implementation process may require significant modifications to current financial assistance and billing and collection practices; let those who are experts in each respective area take the lead.

SPEND AS MUCH TIME EDUCATING AS IMPLEMENTING
Work with your Steering Committee to develop training and educational materials for anyone who may be responsible for the implementation of 501(r). Anyone who is involved in patient care should be equipped to answer patient questions about the hospital facility’s financial assistance and billing and collections policies.

CONNECT WITH COLLECTION AGENCIES
Requirements of 501(r) extend to those vendors who engage in ECAs on behalf of the hospital organization (Treas. Reg. §1.501(r)-6). Engage in discussions with your collection agents about the financial assistance application process, your expectation of their collection process (including halting any ECAs if a patient submits a financial assistance application), and the best way to communicate with them if a patient does qualify for financial assistance after the collection process has started.

DON’T BE AFRAID TO RE-TOOL OR ASK FOR HELP
Compliance with 501(r) is difficult; it will take time and patience as the hospital organization establishes processes and procedures to implement new policy requirements. Be prepared to make changes along the way. Don’t be afraid to ask for help. There are a number of outside consultants who can assess your compliance standing and offer thoughtful feedback. Seek assistance from outside counsel if you need help interpreting the regulation. As of the effective date of the regulation, all entities that are required to comply with 501(r) are required to make certain documents publically available (i.e. Plain Language Summary, Financial Assistance Policy, etc.). Take a look at hospital organization websites to get ideas of how other hospital organizations are complying with 501(r); don’t be afraid to reach out to those hospital organizations to discuss their process and ask questions.

This article only touches the surface of 501(r) implementation. Walk through the regulations slowly and review your current hospital facility policies and procedures to analyze how far from compliance you really are ... you may be closer than you think.

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Telehealth... The New Frontier

BY ANTHEA R. DANIELS

With the implementation of, and at the same time, the potential unraveling of the Affordable Care Act (the ACA fondly named Obamacare), health care providers and suppliers are challenged to do more with less, keep populations of people healthier so health care provision is managed, increase the quality of care and outcomes and improve patient satisfaction all while monitoring, implementing and policing the completion of electronic medical records (EMR) and its meaningful use and maintaining their privacy in a world of data breaches of epic proportions from halfway across the world. So, what is a health care provider and supplier to do? And for us, how can their legal counsel help?

While this article will not address specifically many of those challenges, it will address the specific and discrete topic of the implementation and refinement of telehealth and its role in health care. While I could address many aspects of telehealth, this article will provide general information and will then focus on the reimbursement issues and Ohio laws surrounding the provision of telehealth services. In light of all of the challenges in the first paragraph, why even bother with telehealth? Why? Because telehealth is a possible way to reduce the costs of healthcare while improving access to appropriate health care professionals. It is the new frontier of healthcare and could forever alter the way medical services are rendered.

To begin with, what is telehealth? Telehealth is the provision of health care via some form of telecommunications including video, robots, an IPAD, etc. which includes for the most part, real time streaming of video, and not a delayed transfer of such information. Thus, as the cartoon “The Jetsons” in the 1970’s depicted George’s son Elroy being diagnosed by a doctor via a television hook-up akin to skyping, some 40 years later The Jetsons have arrived. And while we can’t push a button and have a truly gourmet 4-course meal come out of the oven (sorry Stouffers), you can be diagnosed and treated over a video hook-up with a health care provider located far away.

On account of this technology, telehealth will drastically change the landscape of healthcare and how it is provided in the next 5 to 10 years. Pop-up health care virtual offices will open up in numerous places, both rural and urban and in places such as national chain drug stores, discount superbox stores, perhaps company plants, and who knows where else.

So, why would anyone want to see a “virtual doctor” versus a doctor in-person? There are numerous reasons including: (1) a potential lower cost if you are self-pay and don’t have insurance coverage, or you participate in a high deductible employer or payer plan; (2) it is quicker. You may be able to walk into your local CVS and see a virtual doctor immediately for your sore throat and then walk over to the pharmacy for the pharmacist to administer a shot and fill the prescription; (3) you don’t have to wait 2 days or 2 weeks for the appointment, it is close to work or home rather than traveling to the medical building, and you can possibly have your virtual appointment at 11:00 a.m.; and (4) if you are traveling or new to town and you don’t have an established physician patient relationship in that location. Imagine you are on vacation and you get sick with a minor condition. Thus, there is no need to find an urgent care center and wait for an hour to be seen.

Thus, just to name a few of the reasons, these are very attractive accommodations for persons with little free time on their hands. Additionally, maybe patients would be willing to seek out care for their minor illnesses (such as sore throats, etc.), if care was affordable and easily accessible.

So, what are some of the legal impediments around telehealth. First many large academic medical centers and integrated health care delivery systems (large hospital systems), have been providing telehealth services to rural and community hospitals for specialized care, such as telestroke and telepsych services for the last several years. When assisting one of these types of health care providers with legal assistance, there are several key areas that have to be reviewed.

First, follow the money. How does one get paid for providing telehealth services? This is a complex area that has four components. These are the Medicare, Medicaid, commercial and self-pay patients. Obviously self-pay patients are the easiest to address since federal and state payment regulations will typically not apply. Next is the commercial payor who provides health care covered by selling such health care insurance policies to either employers or individuals.

The payment terms for coverage of telehealth services to both the originating site provider of the telehealth services and the provider of the telehealth services will be covered by the provider agreement, which is the insurance company’s document. Thus, what are the terms wherein such insurance company will pay for telehealth providers and how much? This is obviously a negotiated term but often such terms somewhat follow the Medicare corresponding regulations. Thus, it is important to review all commercial payor agreements to see if they will reimburse for telehealth services and, if so, under what conditions and for how much.

Next is Medicaid. As a joint state and federally funded program, each state is in the process or has already established laws to address telemedicine. For example, the Ohio Revised Code Annotated defines telemedicine as “the practice of...
medicine in this state through the use of any communication, including oral, written, or electronic communication, by a physician located outside the state." Thus, there are rules which address a professional outside of Ohio rendering services in Ohio via telemedicine and their need to obtain an Ohio medical license. On January 2, 2015, the Ohio Department of Medicaid established reimbursement rules for telehealth services. This is not uncommon, as many states have yet to adopt such laws and rules. Ohio limits the originating site for telemedicine to a hospital setting, physician office or other unique health care settings, including a nursing facility. Only doctors and psychologists can provide the telehealth. Medicaid will pay the professional component for evaluations and management services (e.g. office visits), inpatient (meaning a person in a hospital) consults, or psychiatry services. Additionally, providers must be at least 5 miles from each other. Thus, Ohio has a viable mechanism for paying certain health care providers for rendering telehealth services.

Lastly, there is Medicare. In a typical rural or urban hospital setting, Medicare will potentially account for 30–50% of the receivables for services rendered. While certain aspects of Medicare coverage is broader than Ohio's Medicaid rules, other aspects are more restrictive. For example, Medicare allows physician assistants, nurse practitioners and clinical social workers to render telehealth services. However, in order for Medicare reimbursement, the patient must be located in a rural setting. Thus, telehealth services provided between two providers within a large city is not possible. Thus, the patient must be located in an area not designated as a Metropolitan Statistical Area. The U.S. Government Accountability Office is studying this payment limitation and its reports are due April 2017. Congress passed a medical innovation bill last July which would require The Centers for Medicare and Medicaid Services and MedPAC to study possible expansion of telehealth. Thus, in order for telehealth to assist the Medicare population, these coverage rules will have to be broadened and allow for more services to be reimbursed.

At the end of January, the Next Generation Accountable Care Organization Model (the model of an ACO established by the Centers for Medicare and Medicaid Services and launched in January of 2016) has included a telehealth waiver to allow telehealth services to be rendered to patients in their home whether in a rural location or not. The American Telemedicine Association has acknowledged that this model is important for the progression of telehealth services. Humana has become important also in the reform of telehealth, with providers, payors and patients not wanting to wait for possible reform in 2017 or later.

Thus, as the ACA and health care continues to gobble up a significant part of the federal and state dollar with the aging of the baby boomers, telehealth, in certain circumstances, is one vehicle to potentially lower costs, improve access and enhance quality and patient outcomes.
Good Sources for Locating Expert Witnesses

Many lawyers need to retain expert witnesses on behalf of their clients. In preparing for trial, lawyers will also want to investigate the credentials, credibility, and track record of experts who will be testifying for opposing parties. Typically, lawyers used to find experts through word-of-mouth referrals or by searching expert directories in print. Aside from recommendations from colleagues, the best way to find expert witnesses today is by searching online databases. In addition to online directories, there are several other non-traditional databases and web sites which can be excellent sources for locating expert witnesses.

Online directories are some of the most important sources for finding experts. Both Lexis Advance® and TR Westlaw® provide subscription databases containing online directories or profiles of expert witnesses from the leading providers (SEAK, ALM, JurisPro, and others). These directories are searchable by name, profession, or topic, and a typical entry for an expert may contain a summary, specialties, affiliations, experience, certificates, qualifications, memberships, and reviews. Both Lexis Advance® and TR Westlaw® also offer searchable databases of CVs and resumes, affidavits and reports, and trial and deposition transcripts, all of which can provide greater insight into the education and qualifications of particular experts. In addition, both vendors provide Daubert databases which track cases where parties challenged experts and courts ruled on questions of admissibility.

There are also a number of free expert witness directories on the Internet. One of the best resources is SeakExperts.com, where lawyers can search for experts by keyword, specialty, or state. ALMExperts.com provides free resumes and profiles for lawyers across the country. Another free directory called JurisPro.com® was created by attorneys and is searchable by industry, name, or topic. JurisPro.com® not only provides contact information and CV’s, but many of their experts offer short videos for insight into their personalities and demeanor. Another excellent free resource is HGEExperts.com, where lawyers can browse or search for general, medical, and forensic experts. FindLaw.com®, which also offers both browsing and searching, usually provides CV’s as well as links to articles experts have written. AMBest.com is also a good free search engine for experts in all 50 states. Although TASAnet.com offers basic expert profiles for free, it is primarily a referral source where lawyers can pay for recommendations.

The Internet is also a resource for free specialized directories of experts in particular fields. For example, medical experts are searchable at SeakExperts.com or the web sites for Registered Nurse Experts (rnexperts.com) and The American Association of Legal Nurse Consultants (aalnc.org). Two gateways for forensic experts include the web sites of the American College of Forensic Examiners (acfei.com) and the American Society of Questioned Document Examiners (asqde.org). ExpertWitnese.com lists experts in business, finance, and technology, newsexperts.com lists intellectual property experts, and LawInfo.com lists criminal and regulatory experts. In addition, Martindale.com is a free source for lawyer-experts on fees or discipline.

In addition to directories, jury verdict and settlement databases can also be good sources for experts. In addition to listing the parties, attorneys, facts, injuries, settlement terms, and awards, typical jury verdict or settlement reports identify all of the experts in a case. Lexis Advance® and TR Westlaw® are the most comprehensive resources for this information.

Other free alternatives for finding experts in particular specialties include college and university websites or academia.edu, where professors share their research. Hospital web sites that profile their doctors can also be excellent resources for finding medical specialists. There are also many professional associations which provide online member directories. Two of the best places to find listings for professional associations include Weddles.com and ASAECenter.org.

Social media sites are also great resources for locating experts. As an example, LinkedIn.com® can be searched by name or topic, or it can be browsed by contact information and profile. Local and national newspapers may also profile expert witnesses in newsworthy cases.

Finally, although it takes a little more time, lawyers may also be able to locate hard-to-find experts through books and articles that they have written. The best way to find these publications are through book and article databases. In addition to online catalogs provided by local law libraries and public libraries, WorldCat.org and the Library of Congress (catalog.loc.gov) are good starting points for searching nationwide catalogs of books and articles by keyword. Surprisingly, Amazon.com also offers a decent search engine for finding books by keyword. For targeted article searching, Ohioweblibrary.org to search EBSCOhost databases such as Academic Search Premier for multi-disciplinary academic and trade journal articles, MEDLINE or Alt Heath Watch for medical articles, or Business Source Premier for business articles. The ohioweblibrary also offers several other journal databases for science and social science articles by potential expert witnesses.

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The Anatomy of a Billing Audit

BY DREW BARNHOLTZ

Imagine someone showed-up at your door and said “We're with Medicare and we've come to audit you.” Better yet, what if you just receive a letter in the mail stating your facility has been audited, owes an overpayment, and that payment for your current and future claims will be held up until Medicare is satisfied you are meeting all applicable requirements. Typical to healthcare, there is a sea of acronyms to describe the entities who audit providers. Medicare auditors include Recovery Audit Contractors (RAC), Zone Program Integrity Contractors (ZPIC) and Medicare Administrative Contractors (MAC). This article will discuss the anatomy and process of a billing audit, common areas of focus in these audits, and best practices to prepare for and minimize the impact of an audit.

RAC AUDIT PROCESS

RACs review claims on a post-payment basis. RACs conduct three types of reviews: (1) automated (2) complex and (3) semi-automated. Automated reviews use data analysis to determine improper payments. This type of review occurs when a provider receives a demand letter for repayment from the RAC without prior review of medical records. The provider has thirty (30) days to dispute the RAC’s findings. If the provider does not dispute the claims within the thirty (30) day window, the FI/MAC will offset the overpayment. If a provider agrees to pay back the overpayment this can be accomplished in one of three ways: (1) By check, (2) Recoupment from future payments, or (3) A payment plan.

The second type of review is a complex review. Complex reviews use medical records to further analyze claims when the RAC’s computer-generated data analysis is insufficient. RACs are limited to requesting ten percent (10%) of average monthly Medicare claims (max 200) per forty-five (45) days per provider number, but RACs may request permission to exceed this cap. A provider has forty-five (45) days to submit records, and the RAC has thirty (30) days after receipt to review the provider’s records. The RAC then sends a determination letter to the provider with its findings.

The third type of review is a semi-automated review. Semi-automated reviews include an automated review during the first part and the submittal of demand letter to the provider explaining billing errors during the second part. Providers have forty-five (45) days to submit evidence to the RAC to dispute the billing errors. If the provider’s documentation refutes the RAC’s findings, then the claims will not be sent for adjustment and the case is closed. If the provider does not submit documentation, or the documentation is not sufficient to refute the RAC’s findings, then the claims are sent to the MAC for adjustment and a follow-up demand letter will be sent to the provider.

ZPIC AUDIT PROCESS

ZPICs audit based on identified target areas determined from data analysis/billing trends, complaint investigations, Office of the Inspector General for the Department of Health and Human Services (OIG) and law enforcement instructions, or congressional mandates. ZPICs can initiate a pre-payment or post-payment audit, and they typically perform unannounced onsite inspections. ZPIC auditors typically send a letter requesting documentation for a number of specific claims. Providers have fifteen (15) to thirty (30) days to submit the requested documentation.

ZPICs may also conduct interviews with beneficiaries and providers’ employees, and use statistical sampling to extrapolate the amount of estimated overpayments based on error rate testing within sampled claims. ZPICs are statutorily authorized to inspect a provider’s business and request medical records as a condition of a provider’s participation in Medicare or Medicaid, but have no legal authority to conduct employee interviews onsite to gather additional information related to the inspection. Employees may decline the interview or request the presence of counsel.

The ZPIC will send the provider a results letter in about six (6) to eighteen (18) months after the inspection. ZPIC audits can be unusually risky because they can result in criminal prosecution or exclusion. ZPICs may also place a provider on pre-payment review in conjunction with a criminal investigation. ZPICs work closely with the MACs and may refer the matter to the MAC for recoupment of overpayments if the ZPIC finds that the provider’s billing errors did not result in fraudulent behavior. If the ZPIC determines that an overpayment exists, the provider will receive a demand letter from the MAC. The provider then has fifteen (15) days to file a rebuttal which gives the provider an opportunity to state why the MAC should not begin the recoupment process. Recoupment (a.k.a. offset or withhold) takes place when the MAC takes future payments and applies them to alleged overpayments. Recoupment may begin forty-one (41) days after the issuance date of the demand letter.

MAC AUDIT PROCESS

A MAC’s role is to process and pay claims for Medicare and to respond to appeals requests from RAC and ZPIC audits. A MAC may also select a provider for an audit based on several criteria: (1) the CMS Comprehensive Error Rate Testing (CERT) program which looks at the MAC error rates in paying claims, (2) Reacting to other providers or patients, or from other government agencies involved in auditing or investigation fraud and abuse, (3) Based on a provider billing a high volume of claims, or (4) Through the results of data-mining techniques looking at unusual billing patterns.

A MAC can perform pre-payment audits by using prepayment edits, including National Correct Coding Initiative (NCCI Edits) and Medical Unlikely Edits (MUE Edits). NCCI Edits are used “to promote national correct coding methodologies and to control improper coding leading to inappropriate payment.” MUE Edits are used “to reduce the paid claims error rate” by setting the “maximum units of service that a provider would report, under most circumstances, for a single beneficiary on a single date of service.” In addition to pre-payment reviews, MACs also use a process...
referred to as the Medical Review Program to perform data analysis and identify errors in a provider’s billing. This is called a post-payment probe and involves the MAC selecting a sample of claims from a particular time period. Typically the MAC will select twenty (20) to forty (40) claims from a six (6) month period.

The MAC can use several corrective actions, including Provider Notification/Feedback, Pre-payment Review and Post-payment Review. If the error is minor then the MAC will typically educate the provider on the appropriate billing procedure. If the error is more severe, the MAC may choose to utilize Pre-Payment Review where a percentage of the provider’s claims undergo medical review before the MAC authorizes payment. The pre-payment review can be lifted once the MAC is satisfied that the provider has corrected the error and is billing correctly. A MAC may also use post-payment review where statistically valid sampling is used to isolate claims.

Part of the process of pre- and post-payment review may involve requests for more documentation referred to as Additional Development Requests (ADR). An ADR typically asks for further records to establish the appropriateness of a claim (e.g., medical necessity, split/shared documentation, timeliness
of signatures, etc.) and providers have forty-five (45) days to respond.

APPEALS PROCESS
If a provider receives a claim denial or the auditor determines an overpayment exists, Medicare allows the provider the right to appeal. Five levels of appeal are available to providers:

1. **Level 1 – Redetermination**: Redetermination is the first level of appeal and is carried out by the FI or MAC. Providers have one hundred and twenty (120) days from the date of the auditor's initial determination to request a redetermination. Providers are allowed to provide additional clinical information during a redetermination. The auditor is required to complete its review within sixty (60) days from submission of the redetermination request by the provider.

2. **Level 2 – Reconsideration**: Reconsideration is the second level of appeal and is carried out by a Qualified Independent Contractor (QIC), not the FI or MAC. The reconsideration request must be submitted within one hundred eighty (180) days after receiving notice of the redetermination decision. The QIC must send its decision to the provider within sixty (60) days of receipt of the request for reconsideration.

3. **Level 3 – Administrative Hearing**: At the third level of appeal a provider is given the opportunity to appeal to an Administrative Law Judge (ALJ). The request for a hearing by an ALJ must be filed by the provider within sixty (60) days following receipt of the QIC’s reconsideration decision. The ALJ will generally issue a decision within ninety (90) days of the hearing request.

4. **Level 4 – Review by the Medicare Appeals Council**: The fourth level of review is performed by the Medicare Appeals Council (MAC Review). A MAC Review request must be filed within sixty (60) days following receipt of the ALJ’s decision. The MAC Review request must specify the issues and findings from the ALJ’s decision that the provider wishes to appeal.

5. **Level 5 – Federal District Court**: The final level of appeal available to a provider is judicial review by a federal district court.

**BEST PRACTICES AND TIPS**
Certain actions can be taken by all providers in anticipation of a potential audit by a RAC, ZPIC or MAC. Prior to an audit providers should establish a compliance committee to identify potential overpayments and implement a plan to reduce the risk of future overpayments. Providers should also designate a point person to serve as the liaison to the auditors and ensure all medical records and other requests are attended to on a timely basis. It is recommended that providers conduct internal billing audits to ensure claims meet Medicare coverage and payment rules. Providers should review the CMS website, the OIG’s Work Plan, as well as the auditors’ individual websites. Finally, it's critical that providers continually educate employees on the audit process through monthly meetings in which recent developments are raised and explained.

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2016 Stark Law Changes
Welcome Relief for Healthcare Providers

BY KELLY SKEAT

Attorneys who regularly represent clients in the health care industry are familiar with the physician self-referral law, commonly known as the Stark Law. The Stark Law is a complex regulatory scheme that impacts many common relationships between physicians and other healthcare providers.

The Stark Law has been criticized as an overly technical regulatory scheme with strict liability standards and heavy financial penalties that can trip up even the best-intentioned providers. A federal court judge, while agreeing that a hospital had violated the Stark Law, recently described it as “impenetrably complex” and “a booby trap.” However, recently finalized regulations issued by the Centers for Medicare and Medicaid Services (CMS) may ease some of these compliance burdens.

STARK LAW BACKGROUND

The Stark Law governs relationships between physicians and the providers to which they refer certain designated health services (DHS). The Stark Law was enacted in response to concerns about overutilization of DHS within the Medicare program. Its restrictions are intended to ensure that all financial relationships between a DHS provider (the DHS Entity) and physicians are for legitimate services, rather than improper incentives to encourage physicians to order unnecessary DHS or choose a particular DHS Entity.

In order to receive Medicare reimbursement for DHS, all financial relationships between the DHS Entity and the referring physician must satisfy a statutory or regulatory exception to the Stark Law. The Stark Law contains exceptions for many common financial relationships, such as space and equipment leases or employment arrangements.

However, these exceptions are complex and contain many technical requirements. If a financial relationship fails to comply with any one of these requirements, the Stark Law is violated and the DHS Entity cannot seek Medicare reimbursement for those services, even if they were medically necessary. Any Medicare reimbursement received from a referral in violation of the Stark Law must be repaid, and the DHS Entity may face additional penalties.

OVERVIEW OF THE REVISIONS

Many DHS Entities have entered into significant settlements to resolve what are perceived as technical violations of the Stark Law, such as expired leases, forgotten signatures or other Stark Law violations that most agree pose a minimal risk to program integrity. CMS has issued revised regulations, effective January 1, 2016, that appear to be addressed at mounting criticism over these penalties. Highlights of the revised Stark Law regulations are summarized below.

REVISIONS TO EXISTING REGULATIONS

Writing Requirements

Many of the Stark Law exceptions previously required the relationship between the parties to be “set out in writing” or pursuant to a “written agreement.” Language was used inconsistently, causing confusion over what satisfied the different exceptions. CMS has now standardized the language, requiring an “arrangement” that is “set out in writing” throughout the Stark Law regulations. CMS has further clarified that the “writing” does not have to be one formal, written contract, but can be established through multiple documents.

A comprehensive written contract remains the best practice for any number of reasons, including clearly establishing the rights and responsibilities of the parties and other contractual matters beyond the scope of the Stark Law. However, when such a contract has not been entered into, providers will now have greater flexibility in establishing Stark Law compliance.

Holdovers

Historically, one of the most common Stark Law violations occurred when parties continued to operate under expired leases or personal service arrangements. Under the previous regulations, if parties operated under an expired agreement for more than 6 months after its expiration, the Stark Law had been violated.

Under the revised regulations, however, parties may now continue to provide services under such expired agreements for an indefinite period. The parties must otherwise comply with the terms of the expired contract and the applicable Stark Law exception. If the parties have adjusted compensation rates, or if the compensation under the expired agreement is no longer fair market value, the arrangement will not be in compliance with the Stark Law.

Signature Requirements

Many Stark Law exceptions require the arrangement up to 90 days after services begin. However, the delayed signature exception may only be used once every 3 years by a DHS Entity for any given physician.

Term Requirements

Many of the Stark Law exceptions previously required the parties to have an agreement with a “term” of at least 1 year. CMS has now clarified that the contract or agreement between the parties does not have to have an express written term and revised the language in several of the Stark Law exceptions to state that the arrangements must have a “duration” of at least 1 year.

NEW EXCEPTIONS

Recruitment of Nonphysician Practitioners (NPPs)

CMS created a new Stark Law exception to allow hospitals and certain other providers to provide recruitment support for nurse practitioners, clinical nurse specialists, physician assistants, certified nurse midwives, clinical social workers and psychologists. Recruitment support involves grants or forgivable loans made to a physician practice to support the hiring of a new healthcare provider. Previously, recruitment support had only been allowed for physicians.

The NPP must primarily provide mental health or primary care services. The parties must enter into a written recruitment arrangement that meets the following requirements:
The CMBA requests nominations for the Hon. William K. Thomas Professionalism Award to honor a lawyer or judge who has significantly contributed to the enhancement of professionalism in the Greater Cleveland legal community by exemplifying the goals of the Ohio Supreme Court’s A Lawyer’s Creed and A Lawyer’s Aspirational Ideals and by furthering the ideals expressed in the Mission of the CMBA. The award will be presented at the CMBA’s Annual Meeting in June.

Submit Nominations by April 15, 2016 To:
Ethics and Professionalism Committee
Attn: Kimberly Vanover Riley, Chair
1375 East 9th Street, Floor 2
Cleveland, Ohio 44114
or e-mail to Heather Zirke at hzirke@clemetrobar.org

1. The arrangement cannot be conditioned on, or take into account the volume or value of, referrals to the party providing the recruitment support.
2. The recruitment support cannot exceed 50% of the NPP’s total compensation over a 2 year period.
3. The total compensation paid to the NPP from all sources cannot exceed the fair market value of the NPP’s services.
4. The NPP cannot have practiced within the hospital’s geographic service area in the year prior to the arrangement.
5. The arrangement cannot violate the Anti-Kickback Statute or other federal or state laws.
6. The arrangement cannot be conditioned on, or take into account the volume or value of, the physician’s referrals to the other party.
7. The compensation paid by the physician must be set in advance, fair market value and commercially reasonable. The compensation cannot use a formula based on a percentage of the revenues raised by the physician while providing services.

Timeshare Arrangements
CMS has issued a new exception that allows physicians to enter into timeshare arrangements for the use of office space, equipment, personnel, supplies and other services. The new exception provides much greater flexibility than the existing exceptions for space and equipment leases. However, the arrangement may only be used by a hospital or physician organization, and must meet the following requirements:
1. It must be in a writing signed by all parties.
2. The arrangement must specify the premises and all included equipment, personnel, supplies or services. The exception is not available for certain equipment, including advanced imaging and complex laboratory equipment.
3. The items covered by the timeshare arrangement must be used primarily for evaluation and management (E&M) services.
4. Equipment must be in the same building where the physician services are furnished, and can only be used to provide DHS that is incidental to the physician’s E&M services.
5. The arrangement cannot be conditioned on, or take into account the volume or value of, the physician’s referrals to the other party.
6. The compensation paid by the physician must be set in advance, fair market value and commercially reasonable. The compensation cannot use a formula based on a percentage of the revenues raised by the physician while providing services.

Impact of the Regulations
While DHS Entities and physicians may have greater flexibility in demonstrating Stark Law compliance following these revisions, the Stark Law and its enforcement have certainly not gone away. Any relationship between a physician and a DHS Entity should always be carefully reviewed for compliance with the Stark Law.

Nearly every exception to the Stark Law still requires the parties to be able to demonstrate that a financial relationship involves fair market value compensation or that it is commercially reasonable. Whether or not compensation paid to physicians by hospitals and other entities meets these requirements has been an area of heavy enforcement focus in recent years, and this trend shows no signs of abating. Carefully documenting compensation methods and engaging third party valuators to confirm fair market value compensation remains a best practice, putting all parties in the best position to defend their financial relationships.

However, the chance of an accidental Stark Law violation leading to a million dollar penalty has been significantly reduced. Many of the changes appear to reflect an intent to returning the Stark Law’s focus to the true violations of program integrity it was designed to prevent. The new exceptions will also allow for more flexible and integrated service delivery. Hopefully, there will be a few less “booby traps” in 2016.
Monday, June 27th
Westwood Country Club

This year’s outing will include lunch, 18 holes of golf and a post-round reception — making the event an experience not to be missed.

Sponsorship opportunities available. Call (216) 696-3525 for info.

2016 Golf Outing Registration
Monday, June 27, 2016 • Registration: 10 a.m. • Tee time: 12 p.m.
Westwood Country Club – 22625 Detroit Road, Rocky River, Ohio 44116

Name ____________________________ Company ____________________________
Phone ____________________________ Email ____________________________

☐ Individual Tickets ($200 each) # _______  ☐ Foursome ($800 each) # _______
☐ I need a pairing  ☐ I do not need a pairing

Golfers: 1. __________________________________________ 2. __________________________________________
3. __________________________________________ 4. __________________________________________

☐ Lunch-only guests ($25) # _______  ☐ Reception-only guests ($50) # _______

Payment Total: _________

☐ Check enclosed (payable to the CMBA)  ☐ Visa  ☐ Mastercard  ☐ American Express  ☐ Discover

Credit Card # __________________________________________ Exp Date __________________________

Signature ______________________________________________________________________________________

Register early — limited space available. The event will take place rain or shine.

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Firm or Office ________________________________________________________________

Address ______________________________________________________________________

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☒ Visa ☐ Mastercard ☐ Discover ☐ American Express

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Signature (if paying by credit card) ___________________________________________

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To inquire, contact James M. Smolinski at (216) 696-3525 x5002 or jsmolinski@clemetrobar.org.

CleMetroBar.org/LRS
### March

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<td>14</td>
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<td>15 Estate Planning Section Lunch &amp; CLE</td>
<td>16 CMBA BOT Meeting</td>
<td>17 Pro Se Divorce Clinic</td>
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<tr>
<td>PLI – 8:30 a.m.</td>
<td>PLI – 8:30 a.m.</td>
<td>Labor &amp; Employment Section Lunch &amp; CLE</td>
<td>PLI – 1 p.m.</td>
<td>– 10 a.m.</td>
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<td>Grievance Committee Meeting</td>
<td>PLI – 1 p.m.</td>
<td>Intellectual Property Law Section Lunch &amp; CLE</td>
<td>Pro Se Plus – 1 p.m.</td>
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<td>22 Green Initiative</td>
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<td>PLI – 8:30 a.m.</td>
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<td>CMBF Grant Committee Meeting – 8:30 a.m.</td>
<td>Court Rules Committee Meeting</td>
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<td>Membership Committee Meeting</td>
<td>Family Law Section Lunch &amp; CLE</td>
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<td>International Law Section Lunch &amp; CLE</td>
<td>(Howard M. Metzenbaum U.S. Courthouse)</td>
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<td>28</td>
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<td>30 Federal Court Training Video – 9 a.m.</td>
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<td>PLI – 8:30 a.m.</td>
<td>3Rs Committee Meeting</td>
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<td>Resilience – Attorney Conduct Video – 8:30 a.m.</td>
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<td>Law School Networking &amp; Social – 5 p.m.</td>
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<td>YLS Council</td>
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<td>Diversity &amp; Inclusion Committee – 4 p.m.</td>
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<td>31</td>
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<td>31 YLS and Litigation Section Happy Hour – 5 p.m. (Velvet Tango Room)</td>
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<td>CMBA Movie Night – 7 p.m.</td>
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### April

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<tr>
<td>4</td>
<td></td>
<td>5 CMBF Executive Committee Meeting – 8:15 a.m.</td>
<td>6 Women in Law Section Meeting</td>
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<tr>
<td>PLI – 8:30 a.m.</td>
<td>CMFB Executive Committee Meeting – 8:15 a.m.</td>
<td>Diversity &amp; Inclusion Committee – 4 p.m.</td>
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<td>Annual Greater Cleveland Bench-Bar Memorial Program (Howard M. Metzenbaum U.S. Courthouse)</td>
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<td>11</td>
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<td>12 ADR Section Meeting &amp; CLE</td>
<td>13 PLI – 8:30 a.m.</td>
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<td>Insurance Law Section Meeting</td>
<td>CMBA Executive Committee Meeting</td>
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<td>JFA Committee Meeting</td>
<td>UPL Committee Meeting</td>
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<td>CMBF BOT Meeting – 4:30 p.m.</td>
<td>Workers’ Comp Section Meeting &amp; CLE (State Office Building)</td>
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<td>International Law Section Meeting</td>
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<td>14 Ethics Committee Meeting Real Estate Tax Section Lunch &amp; Presentation</td>
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<td>18</td>
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<td>19 Pillars Program – 1 a.m.</td>
<td>20 Labor &amp; Employment Law Conference 2016 – 8:30 a.m.</td>
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<td>Estate Planning Section Lunch &amp; CLE</td>
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<td>Grievance Committee Meeting</td>
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<td>21 2016 Labor &amp; Employment Law Conference – 8:30 a.m.</td>
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<td>25</td>
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<td>26 Membership Committee Meeting</td>
<td>22 2016 Labor &amp; Employment Law Conference – 8:30 a.m.</td>
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All events are held at the CMBA Conference Center at noon unless otherwise noted. Information is current as of publication date.
Employment

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New Associations & Promotions

Mazanec, Raskin & Ryder Co., LPA is pleased to announce Tami Zupkow Hannon has been elected to the firm’s partnership.

Susan Audey, Stephen Bittence, Sarah Bunce, Anthony Petruzzi, Jennifer Steinmetz, and Victoria Vance have joined the firm as partners of the firm.

Walter J. Haverfield LLP is pleased to announce that David M. Kroh has joined the northeast Ohio law firm as an associate in its Litigation Group.

Weston Hurd LLP is pleased to announce that Matthew C. Miller has been named a Partner of the firm.

Gallagher Sharp is pleased to announce that Alexis J. Perko and Robert R. Terbrack, Jr. have joined the firm as Associates.

Wickens, Herzer, Panza, Cook & Batista Co. is pleased to announce the election of Attorney Philip J. Truax to shareholder.

Buckley King is pleased to announce the recognition of Rosemary Sweeney, the Firm’s Administrative Partner, and Elizabeth A. Crosby, among the “Top 25 Women Lawyers in Cleveland”. In addition, Crosby, a partner with the Firm, has also been distinguished among the “Top 50 Women Lawyers in Ohio” for 2016 by Super Lawyers.

Banking Practice Group, and Aaron S. Evenchik, Construction and Real Estate Practice Groups, to partners of the firm.

Walter J. Haverfield LLP is pleased to announce that John N. Neal and Jamie A. Price have joined the firm as members of its Cleveland office.

Announcements

Gallagher Sharp is pleased to announce that Jay Clinton Rice has been certified as an Insurance Coverage Law Specialist by the Ohio State Bar Association.

Immigration law firms The Law Offices of Brian J. Halliday and The Law Offices of Marin K. Ritter have announced they have joined forces. The Law Offices of Brian J. Halliday, The Law Offices of Marin K. Ritter and The Law Offices of Brian J. Halliday LLP will maintain offices in Cleveland, Ohio, and will continue to serve clients throughout the U.S. and the world.

Ed Duncan announces his crime novel, “Pigeon-Blood Red,” the first in a trilogy has been published by The Zharmae Publishing Press. It is available exclusively through Amazon at tinyurl.com/pigeonbloodred.

Something To Share?

Send brief member news and notices for the Briefcase to Jackie Barona at jbarona@clemetrobar.org. Please send announcements by the 1st of the month prior to publication to guarantee inclusion.
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