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Bonezzi Switzer Murphy Polito & Hupp Co. L.P.A

New Managing Director, Steven J. Hupp

Steven J. Hupp, Esq.

Bonezzi Switzer Murphy Polito & Hupp Co. L.P.A. is pleased to announce that Steven J. Hupp was selected as Managing Director effective January 1, 2010. Mr. Hupp, 46, is a graduate of John Carroll University (1985) and Cleveland-Marshall College of Law (1988).

BSMPH is a full service defense firm which has grown substantially in the past three years. The firm anticipates further expansion under Mr. Hupp's leadership.

Growing Practice in Workers' Compensation

By Steven J. Hupp, Esq.

When we decided to expand our role in workers' compensation, my goal was to add the same quality attorneys as the Firm has always attracted.

I am pleased to announce the addition of two workers' compensation attorneys to the BSMPH team: Christine Covey and Mary Purcell. Chris and Mary are experienced, extremely well qualified attorneys. Chris has been practicing since 1979 and comes to the firm from Littler Mendleson (formally Duvin Cahn). Mary has been practicing since 1993 and spent several years of her career at Roetzel & Andress and The Vorys Law Firm. Chris and Mary are both certified workers' compensation specialists, Martindale Hubble AV rated and have been selected by their peers as Ohio Super Lawyers.

MMSEA Update: Extension of Reporting Deadlines

by Joseph T. Ostrowski, Esq.

A little over two years ago, Congress passed the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA") 42 U.S.C., § 1395 (b)(7)(8). Section 111 of MMSEA added new and significant mandatory reporting requirements for liability insurance, no-fault auto insurance and workers' compensation (collectively "NGHPs" or non-group health plans) as well as group health plans ("GHPs") and self-insurers. Every settlement, judgment, award or other payment from insurers to a Medicare beneficiary must be reported to Health & Human Services ("HHS") through its Centers for Medicare & Medicaid Services ("CMS"). Likewise, individuals who receive ongoing reimbursement for medical care through no-fault insurance or workers' compensation funds must also be reported to CMS. CMS has a statutory lien on liability claims made by Medicare beneficiaries.

"Responsible Reporting Entities" ("RREs") are those entities that have the responsibility to pay liability claims. Entities qualifying as RREs should have already registered with CMS and should be in "file testing" status. Entities subject to the reporting requirements should have taken the following steps by now to avoid penalties and ensure timely reporting:

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Legal Issues and Alleged Nursing Home Abuse

By Leslie M. Jenny, Esq.

U.S. News & World Report recently reported that "On a given day, 1.5 million people are living in the nation's 16,000-plus nursing homes, and in a typical year more than 3.2 million Americans will spend at least some time in one". The ever increasing number of Americans, especially elder Americans, in nursing homes has led to a dramatic increase in the number of liability claims and suits. Along with the increasing number of such allegations we have also seen an increase in the types of cases. Some of the more common grounds for liability include: premises liability, inadequate security, medical and/or nursing malpractice, understaffing, under budgeting and fraud claims.

What we know, based on experience, is that no matter what the basis for the claim against the nursing home - we, as the defense, are NEVER starting out on a level playing field! The scale should be presumed from the outset to be tipped against the nursing home or long term care facility. This is, indeed, a reality generated by perception. The general public does not want to envision a future that involves the need for long term nursing home care and have a negative impression of the care that is rendered in such a setting. These factors combine to make nursing homes particularly susceptible to liability claims. The following represents a brief analysis of the most frequently encountered of these claims.

1. Premises Liability

Premises cases involving nursing homes can be as simple and commonplace as a "slip and fall" or as complicated as a broken hot water heater that malfunctioned and resulted in scalding water being pumped into a bath where a resident was bathing resulting in third degree burns over 40% of her body and triggering an immediate heart attack which claimed her life. From the simple to the complex, even premises liability cases involving long term care providers require extra vigilance.

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Legal Issues and Alleged Nursing Home Abuse Cont.

2. Inadequate Security

Inadequate security cases can run the gamut from a resident who wanders away from the facility to a resident who is assaulted by another resident, staff member or visitor. These cases can be especially problematic for facilities with dementia units or a large population of residents with behavioral issues. It is important to appropriately evaluate during the claim and/or early litigation stages whether a cross-claim against another party defendant or a third party complaint against a non-party should be filed in these matters given the right to potential apportionment under Ohio's joint and several liability statutes.

3. Medical/Nursing Malpractice

These claims are the traditional types of claims seen for years in long term care cases. The medical and/or nursing malpractice case typically involves a resident who has been diagnosed with pressure sores, malnutrition, dehydration, falls, fractures, lacerations, medication errors, rapid decline in health or infection and/or sepsis. The relatively new twist on these types of claims is that many, if not most, of these "injuries" are now considered to be "Never Events" by the Centers for Medicare Services (CMS). "Never Events," according to CMS, are those medical events or complications that should "never" happen and, therefore, CMS has decided that they will not reimburse care relating to these "Never Events". While the concept of "Never Events" has not yet made widespread appearance in nursing home litigation, one should remain on watch for the potential of such arguments becoming commonplace.

4. Understaffing/Under Budgeting

By history, claims for injury to a resident or residents as a result of understaffing and under budgeting was seen only in those monster-sized cases being litigated in the nation's hot spots like Florida, Texas and California. These claims are now seen regularly in Ohio. Almost every case these days seems to possess, at its core, an allegation that the care was negligent because the home sacrificed adequate care for profit. This claim becomes especially problematic where the resident at issue was scored by MDS assessment as requiring a high level of care, which then was not provided based on the documentation in resident's records. Daily census reports, resident acuity levels, staffing sheets and other documents become much sought after in paper discovery. One should carefully evaluate the potential for this type of claim and assemble these documents early on in the claim/litigation process so as to analyze the potential for problems in this area. These cases are not just about the care provided to the particular resident any longer.

5. Class Actions

Ohio has not seen these types of cases in this arena. Nursing home class actions can involve claims of intentional understaffing resulting in insufficient staff being present to care for the needs of an entire facility leading to injury to multiple, if not all, residents. A class could also be certified on the basis that the nursing home was engaging in a practice of increasing the residents' acuity level, thereby, defrauding residents and insurers. Claims of inadequate training and policies can also make an appearance based on an allegation that such failures resulted in negligent care to multiple (if not all) residents. These can be multi-million dollar cases if certified.

6.Fraud/FalseClaimsAct/Qui Tam

These cases are provided for by federal law under the False Claims Act which provides that persons with evidence of fraud on federal programs (Medicare) may bring a lawsuit on behalf of the federal government. The person bringing such a claim is entitled to 15-30% of the monies recovered. Examples of claims brought under the False Claims Act would include billing for services not rendered, misrepresenting the nature of the illness and falsely increasing the severity of illness to increase reimbursement.

As with all litigation, early evaluation and preparation are key to a successful defense. The more difficult challenge is to recognize the ever-changing landscape of WHAT issues we need to be prepared to handle. Thus, some of my recommendations in this regard would be:

- Obtain an early report from opposing counsel as to the nature of the claim. Never underestimate the power of a phone call to the other side.
- Collect records, census data, staffing sheets and nursing policies/ procedures at the initiation of the suit. Don't wait for requests for discovery from opposing counsel as this approach leaves little time for compilation and evaluation.
- Early meetings with the home's administrative staff to discuss the potential for any and all of the above claims and formulation of a game plan for addressing such allegations. Be proactive in your approach. An approach that only envisions a defensive strategy is not best!

Feel free to contact me with questions regarding any of the issues addressed herein.

Leslie M. Jenny, Esq.

Great Divorce Timing For the Wealthy

By Kimrey D. Elzeer, Esq.

It is common to hear the story that one spouse to a 25+ year marriage decides they want a divorce. The familiar stated reason? "We don't have anything in common anymore." However, in this unstable economy, the outcome of the divorce is anything but familiar. If you are the wealthier spouse, a divorce in today's market may be extremely advantageous. Real estate values are down, business values are down, large income earners have lost their lucrative jobs and have taken jobs earning much less and/or are not earning the bonuses they traditionally received. Since assets and income are down, the wealthier spouse can buy out the other spouses' interest in marital assets for significantly less. Because their income is down, they will likely pay less spousal and child support and save money in the end. Courts do not take into account what the value of an asset "was" or "will be". They look at

what the property is worth today (i.e., sometime between date of filing and date of final hearing). If the wealthier spouse is going to "market-time" their divorce, this could be a great financial opportunity. That is, however, unless a prenuptial agreement exists that makes the outcome worse for the wealthier spouse due to a drop in their pre-marriage asset values. Prenuptial agreements negotiated when the pre-marriage asset values were significantly higher may end up awarding the less-wealthy spouse an outrageous and unfair settlement amount.

Kimrey D. Elzeer, Esq.

MMSEA Update: Extension of Reporting Deadlines Cont.

1. Develop processes to determine which settlements are reportable and how the reporting responsibility is allocated between the defendant and its insurer (if any). Several factors determine whether a settlement is subject to Section 111 reporting, including the timing of the allegations, value of settlement, nature of claim and identity of the defendant and plaintiff.
2. Revise releases and other settlement documents to address the reporting requirements. Defendants should consider developing reporting Fact Sheets to confirm the accuracy of reportable information with plaintiffs.
3. Update indemnification and confidentiality provisions in the release and other settlement documents to reflect reporting penalties and duties.
4. Develop a process to utilize the model language safe harbor, which can exempt entities from reporting obligations in certain situations.
5. Implement policies and procedures to protect data confidentiality and limit the use, access and disclosure of the reportable information, as required by the Data Use Agreement that reporting entities must sign with the federal government when registering for the Section 111 program.
6. Review contracts with third party reporting vendors (if any) to allocate responsibility for penalties, duties and Data Use Agreement confidentiality obligations.

For the non-compliant, the new reporting law imposes hefty penalties for failure of an RRE to comply with the new requirements. Of primary significance, the law allows for a civil penalty of $1,000 per day of non-compliance with respect to each individual for whom information should have been submitted.

In early February, 2010, the American Insurance Association, the National Association of Mutual Insurance Companies and the Self-Insurance Institute of America groups urged HHS to delay implementation of the mandatory reporting requirements indicating that "The Agency" has yet to demonstrate that the new reporting system will properly function. The trade groups identified five major concerns supporting a delay in implementation:

1. CMS has yet to provide final guidance as to which entity has reporting responsibility in situations involving risk-sharing arrangements where more than one RRE has a share in the settlement.
2. Insurers have serious concerns with the mandatory requirement to submit extensive private information such as a Medicare beneficiary's social security number or health insurance claim number. In essence, RRE's are being directed to obtain information from beneficiaries that CMS itself advises those same beneficiaries to provide only to their physician or other Medicare provider. Therefore, this information is often not readily available to an RRE without a HIPPA release.
3. There are serious concerns that CMS is not properly employing the highest-level security and encryption technology available to ensure the privacy of personally identifiable information that is required to be submitted by RREs.
4. CMS has only recently allowed entities to test the mandatory electronic reporting capabilities and interfaces with the CMS systems. Given that there are more than 24,000 entities registered to report, the time contemplated for testing the system is insufficient to guarantee successful implementation by April 1, 2010.
5. There is a concern that the $1,000 per day, per claim, penalty provision is excessive and, at a minimum, it should not be assessed on the first reports submitted by any RRE.

In response to the aforementioned concerns, HHS announced on February 16, 2010, that it will extend the deadline for reporting requirements under the Medicare Secondary Payer Act from April 1, 2010, to January 1, 2011.

Even though reporting has been delayed until the first quarter of 2011, defendants and insurers must determine if and when they are subject to the reporting obligation. CMS specifically requires entities that have an "expectation of having claims to report" to register in enough time to allow a full calendar quarter to test their reporting protocol. The newly-announced delay does not change the effective dates for what is reportable. RREs must still identify Total Payment Obligations to Claimants ("TPOCs") in existence on or after January 1, 2010, and Ongoing Responsibility for Medicals ("ORMs") in existence on or after July 1, 2009.

Information and official instructions for Section 111 and its implementation including data reporting procedures can be found on the CMS website.

Joseph T. Ostrowski, Esq.

Updating the Law for Medical Malpractice

by Jennifer R. Becker

This past summer, two noteworthy Opinions were issued by the Ohio Supreme Court regarding medical malpractice cases. In *Schelling v. Humphrey*, 123 Ohio St.3d 387, 2009-Ohio-4175, the Supreme Court of Ohio addressed the question of whether a plaintiff could pursue a negligent-credentialing claim against a hospital without a prior finding that the plaintiff's injury was proximately caused by the negligence of an independent-contractor physician. In *Schelling*, the physician who was the subject of the negligent -credentialing claim had filed for bankruptcy protection and, thus, there had been no finding that plaintiff's injury was caused by the physician's negligence. *Id*., at ¶ 1. The Supreme Court of Ohio held that because the doctor's bankruptcy filing impeded the plaintiffs from pursuing their claim against the doctor, through no fault of their own, the plaintiffs could pursue their negligent-credentialing claim against the hospital by first proving that the doctor was negligent and that his negligence was the proximate cause of plaintiff's injury. *Id*., at ¶ 4.

Normally, either a plaintiff must obtain a prior determination that a doctor committed medical malpractice and that the malpractice proximately caused the plaintiff's injury, or the doctor is a party to the case that includes the negligent-credentialing claim against the hospital. *Id*., at ¶ 32. However, in the unusual circumstances of this case, the doctor was no longer amenable to suit because of the bankruptcy stay and discharge, and the plaintiffs, through no fault of their own, could not maintain their malpractice claim against him. *Id*. Therefore, the plaintiffs were permitted to pursue their negligent-credentialing claim against the hospital.

The Court also explained that bifurcating the determination of whether the doctor committed medical malpractice and the plaintiffs' negligent-credentialing claim against the hospital would appropriately allow the fact-finder to determine whether the doctor was negligent in his medical treatment of plaintiff and whether this negligence was the proximate cause of injury *before* the hospital must defend the rest of the negligent-credentialing claim at trial. *Id.*, at ¶ 31. Only if the plaintiffs prevail on the issue of the doctor's alleged malpractice should the rest of the negligent-credentialing claim against the hospital proceed. *Id*. The holding of the Ohio Supreme Court in *Schelling* was fact specific.

In the second case, *Hodesh v. Korelitz*, 123 Ohio St.3d 72, 2009-Ohio-4220, the sole legal issue was whether a "contingency agreement" between plaintiff and one of the defendants in the medical-malpractice action should have been disclosed to the jury. *Id.*, at ¶ 1. The Ohio Supreme Court held that a Mary Carter agreement must be disclosed to a jury. *Id.*, at ¶ 6. However, in this case, the agreement was not a Mary Carter agreement and the trial court did not abuse its discretion by not requiring disclosure of the agreement. *Id*., at ¶ 18.

The Court stated that all settlement agreements in Ohio must be free from collusion, regardless of whether they fall under the category of a Mary Carter agreement. *Id*., at ¶ 9. The Ohio Supreme Court has defined a Mary Carter agreement as "a contract between a plaintiff and one defendant allying them against another defendant at trial". *Id*., at ¶5, quoting *Vogel v. Wells* (1991), 57 Ohio St.3d 91, 93, 566 N.E.2d 154. When reviewing a settlement agreement to determine whether it is collusive, the Court is guided by the typical Mary Carter agreement provisions, specifically a provision that decreases the settling defendant's liability in proportion to an increase in the non-settling defendant's liability. *Id*., at ¶ 9, citing *Vogel*, at fn. 1. Courts are concerned that such an arrangement provides an inducement for the settling defendant to "secretly conspir[e] to aid the plaintiff's case". *Id*., quoting *Ziegler v. Wendel Poultry Servs., Inc.* (1993), 67 Ohio St.3d at 17, 615 N.E.2d 1022. This collusive purpose is obviated when the settling defendant is at risk of liability in a significant amount. *Id*.

In *Hodesh*, after reviewing the agreement between plaintiff and defendant, the Supreme Court determined that the agreement was not collusive because: 1) there were several contingency clauses under which the hospital would pay less if the damages were less and, thus, the hospital had a financial interest in a lower verdict; 2) the hospital was required to pay a certain amount, if the other defendant or his insurance company did not pay within thirty (30) days and an appeal by the other defendant would delay payment past thirty (30) days, triggering this provision (this provision made it less likely for the hospital to collude with plaintiff to increase the verdict against the co-defendant because the higher the verdict the more likely co-defendant would appeal, which would cause the hospital to pay a sum certain under the agreement); and 3) the trial judge saw no signs of collusion during the trial. *Id.*, at ¶ 12-14. Thus, the Ohio Supreme Court held the agreement was not collusive. *Id*., at ¶ 18.

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