

Staying Well Within The Law



Fox Rothschild ^{LLP}
ATTORNEYS AT LAW

A newsletter on the current legal issues facing today's health care industry

First Quarter 2014

Filling Staffing Needs: Can Foreign Physicians Save the Day?

By Catherine V. Wadhvani and Matthew J. Redding

The Patient Protection and Affordable Care Act (the Affordable Care Act) contains a number of provisions aimed at increasing access to health care insurance to millions of Americans without coverage. This increased access to health care insurance will lead to an increased demand for physician services. In order to provide for the increase in physician demand, the Affordable Care Act introduced a number of incentives aimed at increasing the number of physicians in the workforce, including modifying federal Medicare payments for medical residency training, authorizing additional funding for medical residency training, and offering additional loan forgiveness and scholarship programs for medical students. While these incentives may eventually increase the output of physicians in the workforce, the shortage of physicians available is a current problem.

Medical practices, hospitals and other health care employers should affirmatively seek options to address the increased patient expectancy before it becomes an overwhelming concern. One viable option these employers should consider is sponsoring foreign physicians through a J-1 Waiver Program. This article provides a brief overview of the requirements.

An Option for Meeting Increased Patient Demands

With the anticipated increase in demand for physician services, one way for some physician employers to meet patient demand is to consider sponsoring a J-1 Exchange Visitor physician who is completing graduate medical education and training in the U.S. In a patient-care context, this may be a good option for health care providers who treat underserved patient populations.

There are many means by which an employer may sponsor a foreign physician for employment, and in some cases, very highly qualified physicians may self-petition for U.S. permanent residence. With regard to certain J-1 Exchange Visitor physicians, there is an option which requires the physicians to commit to full-time practice for at least three years in a shortage area(s) or providing services to medically underserved patients.

Employing a foreign physician through this option can help meet patient demand and provide consistency of care over the three-year commitment period. Further, during that time the physician may become well established in the area and agree to stay beyond the three-year commitment. This can greatly benefit the underserved patient population as well as bring much-needed relief to a busy practice where existing doctors often have stressful schedules.

Sponsoring a J-1 Physician

A foreign physician who completes graduate medical education and training in J-1 Exchange Visitor status under an ECFMG-sponsored (Education Commission for Foreign Medical Graduates-sponsored) program is subject to a 2-year home-presence requirement. This means that after completing training, the J-1 physician is obliged to return to his or her home country for a two-year period before being

permitted to change status to H-1B or L-1 in the U.S. or obtain U.S. permanent residence (i.e., a "greencard").

Recognizing long ago that there are many areas of the country in need of highly trained physicians, Congress provided for J-1 Exchange Visitor physicians to be absolved of the two-year home presence requirement in exchange for providing care on a full-time basis to patients in areas that have been designated by the U.S. Health and Human Services agency as medically underserved or to patients who are underserved. As mentioned, the commitment is for at least three years. Approval of a J-1 Waiver application means that the two-year home presence requirement of the J-1 Exchange Visitor physician is "waived", i.e., the foreign physician is the beneficiary of a "J-1 Waiver".

There are many J-1 Waiver programs available for clinical care, including the Conrad State 30 program, as well as programs such as the Appalachian Regional Commission and Delta Regional Authority programs. There are of course other types of waiver opportunities such as Health and Human Services clinical and non-clinical waivers, Veterans Administration waivers and waivers through other government agencies, but those listed are among the most commonly used for physicians who will engage in clinical care for patients. It should be noted that some programs are limited to specific geographic areas and/or practice types. There are also a few waiver options which do not require a shortage-area commitment of the foreign physician, including persecution waivers and hardship waivers.

What Are the J-1 Waiver Requirements?

There are various options for obtaining a J-1 Waiver. One of the most widely used J-1 Waiver programs is the Conrad State

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30 program. Under this program, the basic requirements are as follows:

- Contract between the waiver sponsor and the physician for full-time patient care for at least three years
- Full-time work in a Health Professional Shortage Area (HPSA), a Medically Underserved Area (MUA) or serving a Medically Underserved Population (MUP)
- Agreement to commence work within 90 days of receiving the waiver

These are the basic requirements under the Conrad State 30 J-1 Waiver Program. There may be, and typically are, additional requirements dictated by each state health department, such as documentation of the need for specialty medical care if a specialist is being sponsored, etc. The requirements vary from state-to-state and are sometimes revised.

Further, although the minimum J-1 waiver commitment is for a three-year period, if extenuating circumstances arise through no fault of the foreign physician, it is possible that the foreign physician may transfer to a different shortage-area employer.

In addition, it should be noted that the rules and requirements are different in the other J-1 Waiver Programs, which are too diverse to be appropriately addressed in this article.

What Are the J-1 Waiver Processing Steps?

Processing steps vary slightly among the different J-1 Waiver programs. By way of example, a J-1 Waiver Application under the Conrad State 30 program is first filed by the waiver sponsor (prospective employer) with the state health department in the state where the physician will provide patient care. To be clear, the employer seeks the J-1 waiver on behalf of the foreign physician, so the responsibility for filing the waiver application is the prospective employer's.

If the state health department supports the placement of the J-1 physician with the waiver sponsor, the state health department will forward the J-1 Waiver Application to the U.S. Department of State (DOS) Waiver Review Division with a request that it recommend to the U.S. Citizenship and Immigration Service (USCIS) a waiver of the J-1 Exchange Visitor physician's two-year home-presence requirement.

The DOS Waiver Review Division will review the J-1 Waiver Application anew, typically taking four to eight weeks for processing. If DOS agrees with the placement, it will forward the J-1 Waiver Application to USCIS with a favorable recommendation.

USCIS will conduct final processing of the J-1 Waiver Application. Generally, USCIS will take about a month to issue a decision, but processing times may change over time.

With the issuance of an approval notice, the J-1 Physician's two-year home-presence requirement is "waived", but still requires at least three years of work in H-1B status to meet the J-1 Waiver commitment.

When Can the Doctor Begin Working?

While approval of a J-1 Waiver application absolves the J-1 Physician of his or her home-presence requirement, it does not provide the physician with a right to remain in the U.S. nor with authorization to work toward completion the three-year J-1 Waiver commitment. A work-authorized status must be secured.

In the example of the Conrad State 30 Waiver, in order for the waived physician to begin working toward completion of the three-year J-1 Waiver commitment, the sponsoring employer should file a petition for H-1B status on behalf of the physician. Note that the H-1B petition is the prospective employer's petition. Pursuant to Department of Labor Regulations, the employer may not require the foreign physician to pay legal fees

or related expenses, nor recoup these from the foreign physician in any manner. When H-1B status is in place (i.e., an I-94 record has been created confirming the physician's H-1B status), the physician may report for employment.

Conclusion

The Affordable Care Act's expansion of health care insurance availability will magnify the need for additional physicians in the workforce to meet patient needs. Practices, hospitals and other employers of physicians should affirmatively consider their options to handle the expected increase in their patient base. An attractive option that may be unknown to many employers is sponsorship of a foreign physician through a J-1 Waiver program.

Health care employers with underserved patients may find that sponsoring a J-1 Exchange Visitor physician may be just what the doctor ordered to meet burgeoning patient requirements expected to result from the enactment of the Affordable Care Act. With the help of experienced immigration and contract law counsel, the process should go smoothly and result in benefit to underserved patient populations, the sponsoring employer and the foreign physician.

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Not So Light Duty: The Obligation To Accommodate Employees Injured at Work

By Mark Tabakman

When an employee is injured on the job and files a workers compensation claim, the goal of the employer is to get that person back to work so the workers compensation costs

do not continue to rise. Many times, the employee gets a doctor's note authorizing a return to work but only on "light duty." This usually means some restriction is placed

on the employee's activity (e.g. cannot lift 10 pounds). Although this gets the employee back, this assignment to light duty is often abused by employees who try to

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take advantage and stretch their light duty assignment to last weeks, months, or (as I have seen on occasion) years. This abuse can be dealt with.

In an ideal world, light duty positions should be used as staging areas where injured employees can recuperate and return to their full-time jobs while still being productive. Light duty positions, however, should not be intended to be a permanent post, but a temporary way station or bridge between an inability to work due to injury and a return to full employment status; they are intended as a shield to protect the temporarily disabled, and not as a sword by which a person who is otherwise unqualified for the position can demand a permanent posting.

The New Jersey Law Against Discrimination (NJLAD) does not require that an employer create an indefinite light duty position for a permanently disabled employee if the employee's disability, absent a reasonable accommodation, renders him otherwise unqualified for a full-time, full-duty position. Thus, consistent with the NJLAD, an employer may reasonably limit light duty assignments to those employees whose disabilities are both temporary and not inconsistent with the duties of the light duty

assignment, and, conversely, the availability of light duty assignments for temporarily disabled employees does not give rise to any additional obligation on the part of the employer to assign indefinitely a permanently disabled employee to an otherwise restricted light duty assignment.

In sum, an employer may, consistent with the NJLAD, terminate the employment of an employee who, after consideration of available reasonable accommodations, nevertheless is no longer able to perform the essential functions of his job. However, the employer is not obliged to do so. An employer may, on either a temporary or long-term basis, seek to retain disabled employees in either modified or different job postings.

The following are some guidelines employers should use when dealing with light duty situations and dealing with the employee's Health Care Provider (HCP):

- 1) Send the HCP an accurate list of the employee's duties, including essential job functions and physical requirements.
- 2) An accurate, up-to-date job description prepared is the gold standard to establish essential job functions.

- 3) Information from the HCP will set the parameters of the time frame of the light duty accommodation.
- 4) Do not be satisfied with repeated notes stating that the employee will be "re-examined in two weeks."
- 5) Always obtain updated information from the employee's HCP concerning the employee's expected return to work date and any restrictions upon the employee's return to work. It is permissible to request clarification or additional information.

Most importantly, I strongly recommend implementing a light duty policy that will address all of the issues and concerns that swirl around the concept of "light duty," including the setting of some temporal limits on how long a stint of light duty can last.

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IRS Allows Sponsors To Loosen the Use-It-Or-Lose-It Rules For Health FSAs

By Michelle M. McCarthy

On October 31, 2013, the IRS issued Notice 2013-71, which modifies the "use it or lose it" rules for Section 125 cafeteria plans.

The modification permits Section 125 cafeteria plans to be amended to allow up to \$500 of unused amounts remaining at the end of a plan year in a health Flexible Spending Account (FSA) to be paid or reimbursed to plan participants for qualified medical expenses incurred during the following plan year, provided the plan does not also incorporate the grace period rule. This carryover of up to \$500 does not affect the maximum amount of salary reduction contributions that an employee is permitted to make for the year (\$2,500 adjusted for inflation after 2012).

Notice 2013-71 was issued in response to public comment on the "use-it-or-lose-it" guidance, arguing the difficulty for employees in predicting their future needs for medical expenditures, the desirability of minimizing incentives for unnecessary spending at the end of the year or grace period, the possibility that lower- and moderate-paid employees are more reluctant than others to participate because of aversion to even modest forfeitures of their salary reduction contributions and the opportunity to ease and potentially simplify the administration of Health FSAs.

Accordingly, an employer, at its option, is permitted to amend its Section 125 cafeteria plan document to provide for the carryover immediately following the end of the plan

year, of up to \$500 of any amount remaining unused in a health FSA. The carryover does not count against, or otherwise affect, the indexed \$2,500 salary reduction limit applicable to each plan year; although a plan adopting this carryover provision is not permitted to also provide a grace period of 2 ½ months during which unused benefits or contributions remaining at the end of the plan year may be reimbursed to employees for qualified benefit expenses incurred during the grace period.

To utilize the new carryover option within a Section 125 plan offering, a health FSA must adopt a carryover provision amendment on or before the last day of the plan year from which amounts may be carried over. The amendment may be effective retroactively

to the first day of that plan year provided that the plan operates in accordance with the notice and informs participants of the carryover provision. Also, if the plan has provided for a grace period, and is being amended to add a carryover provision, the plan must also be amended to eliminate the grace period provision by no later than the

end of the plan year from which amounts may be carried over. Since the Notice goes into effect immediately, employers can elect to amend their plans as early as for the 2013 plan year; however, if the plan has a grace period in effect, employers must either wait to amend their plan until the 2014 plan year or amend out of the grace period for 2013.

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OFCCP Continues To Engage in Efforts To Assert Jurisdiction Over the Health Care Industry and Hospitals That Participate in or Receive Payments From TRICARE

By Kenneth A. Rosenberg and Jordan Kaplan

Over the past several years, the U.S. Department of Labor's (DOL) Office of Federal Contractor Compliance Programs (OFCCP) has engaged in ongoing efforts to assert jurisdiction over hospitals and the healthcare industry based on its assertion that these entities are government subcontractors within the meaning of 41 C.F.R. § 60-1.3.

Pursuant to this regulation, a subcontract constitutes any agreement between a contractor and a third party for either: (1) the purchase, sale or use of personal property or non-personal services, which is necessary for the performance of any one or more contracts (Prong One); or (2) under which any portion of the contractor's obligation under any one or more contracts is performed, undertaken or assumed (Prong Two).

The OFCCP has argued that hospitals are subcontractors under both of these prongs when they became involved in TRICARE networks or accepted reimbursement payments from TRICARE. These efforts were temporarily stalled when the DOL's Administrative Review Board (ARB) ruled on November 13, 2012 that the OFCCP did not have jurisdiction over Florida Hospital, as a subcontractor, simply because it provided medical services to TRICARE beneficiaries as part of Humana Military Healthcare Services' (HMHS) integrated health care delivery system based on Section 715 of the NDAA. *OFCCP v. Florida Hospital of Orlando*, ALJ Case No. 2009-OFC-0002 (October 18, 2010). Section 715 of the NDAA, in relevant part, provides that "a TRICARE managed care support contract

that includes the requirement to establish, manage or maintain a network of providers may not be considered to be a contract for the performance of health care services or supplies on the basis of such requirement."

However, on July 22, 2013, the ARB heard the OFCCP's motion for reconsideration in *OFCCP v. Florida Hospital of Orlando* and reversed its initial decision. In doing so, the ARB found that while Section 715 of the NDAA precludes the OFCCP from asserting jurisdiction over hospitals where they have merely performed, undertaken or assumed a portion of a federal contractor's obligation to provide medical services to TRICARE beneficiaries, (Prong Two of the subcontractor definition), it did not prevent the OFCCP from demonstrating that a hospital had otherwise entered into a subcontractor relationship with the government under Prong One. Specifically, the ARB stated that Section 715 of the NDAA did not create a blanket prohibition of OFCCP jurisdiction over hospitals and a separate analysis must be performed to determine if Prong One jurisdiction still exists.

Under the facts and circumstances of *Florida Hospital*, the court found that Prong One jurisdiction still applied because the hospital's contract with HMHS was for the performance of non-personal services, and the purchase of the hospital's services was necessary for the managed care support contract between HMHS and TRICARE.

It is of note, however, that the analysis of OFCCP jurisdiction did not end there. The ARB recognized the hospital's argument that TRICARE may qualify as a federal

financial assistance program thereby falling within another exception to the OFCCP's jurisdiction. As such, the ARB remanded the case back to the ALJ for additional fact-finding on the issue as to whether Congress intended for TRICARE to be a federal financial assistance program. If the ALJ finds that TRICARE is a federal financial assistance program, then the hospital will not be subject to OFCCP jurisdiction.

As the OFCCP has been attempting to assert jurisdiction over the health care industry and hospitals based on their acceptance of TRICARE reimbursement payments, these entities should continue to monitor the *OFCCP v. Florida Hospital of Orlando* case because its outcome could turn them into a federal contractor/subcontractor thereby creating significant new compliance issues for them in the future. In the event a hospital or healthcare provider has any questions about the potential implications regarding this case, they should consult with counsel for guidance.

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Managing Audit Demands

By William H. Maruca

Few pieces of mail cause as much heartburn among physicians as the dreaded audit letter from a third-party payor. Your first reaction may be a vision of a six-figure refund demand. Worse yet, you may treat the letter as a nuisance and not give it the attention it deserves. Post-payment review audits are a fact of life in medical practice, and with the proper preparation and response, they do not have to be disruptive or catastrophically expensive.

Each payor has its own audit, refund and appeal mechanism. This series will focus on the protocols currently in place by the major payors in Western Pennsylvania. The first installment will look at Highmark Blue Cross Blue Shield.

The Provider Agreement

If you are a participating provider in Highmark's plans, you will have signed a participation agreement that addresses how overpayments are determined and sets out your rights if you disagree with a refund determination. "Overpayment" is defined as any payment greater than the amount actually due under the provider agreement regardless of the reason, and also includes any payment during any period in which a provider failed to satisfy any applicable participation criteria. If you receive what Highmark determines to be an overpayment, the plan can set off any overpayment against any future payments in addition to other rights under the agreement. If no future payments are due, you are required to reimburse the plan within 30 days of demand. If you request a Medical Review Committee (MRC) hearing, interest is charged beginning 30 days after the overpayment is determined by the MRC. If you have entered into a group account, each member physician agrees to be jointly and severally liable for overpayments and misreporting by any and all partners to the account.

The agreement authorizes the plan to perform reviews (on-site or otherwise), audits and statistically valid sampling techniques that are deemed necessary to include, but not be limited to, credentialing (for credentialed networks) and peer review program activities, medical practice audits, medical necessity reviews, data validation

reviews, billing and claims payment audits, coding audits and quality improvement audits.

The Document Request

Typically, the first letter you receive will be from the Financial Investigations and Provider Review (FIPR) section and will request copies of complete patient files for the dates of service and patients listed (generally about 20 claims). Although you must provide notes from the specific dates of service they request, they will consider documentation from outside the review period that could assist in determining whether the claims were medically necessary and properly coded. You also are encouraged to include a typed transcript of any records which may be difficult to read, and a key of any abbreviations that are unique or created for your specific record keeping.

Tips

Your thorough and careful response to the first audit letter can be your best opportunity to minimize your liability under an audit. Reviewers often are under time pressure, and anything you can do to assist them in finding the information they need in your records will improve your outcome. The following tips are applicable to audits by Highmark and most other payors:

- Review each claim carefully before you submit the copies, and include any additional progress notes or information that may help a reviewer understand why you performed the service billed in each claim and why you coded it the way you did.
- If your notes are hard to read, include a transcript and explanation of your abbreviations.
- Also, consider including external records such as lab or other diagnostic test results, hospital records and notes from other physicians who have treated the patient during the time in question to assist in building a case for medical necessity.
- I generally recommend that you dictate a brief paragraph for each patient with a short summary of your treatment history of each patient, including the patient's various diagnoses and all their

medications. This note should be dated on the date you dictate it.

You may want to consider having your charts reviewed by an outside consultant before you send them in. This should always be done through counsel so that the consultant's report, if unfavorable, would be protected as privileged to the extent possible. If the audit is focusing on evaluation and management (E&M) visits, a consultant may find that you have undercoded some visits even if you have upcoded others, and this information may be helpful when finalizing the audit results.

NEVER alter or backdate a medical record. If you discover errors in your records, such as a transposed or incorrect date, attach a currently dated explanation.

Remember that each dollar saved in the review of the initial sample will be multiplied many times over if the plan extrapolates the results over a large group of claims, as is often the case.

Note that Highmark, like most plans, is usually flexible about the deadline when large quantities of records are requested, and you can often get an extension if necessary.

The Demand Letter

After Highmark reviews all the information you submit, they will send you a letter with the results of the review and instructions about your options for responding. If you agree with the results, you will be given the choice to repay the amount in a lump sum, have it offset against future payments or pay it in installments. Installment payments will bear interest and generally not exceed six months without a compelling reason. Most practices have told me that offsetting payments creates accounting problems as well as interrupting cash flow, so if you agree with the amount but do not have the immediately available funds, it is sometimes beneficial to use a line of credit or other source of financing to pay the refund in a single payment.

The demand letter will generally set forth the basis for the audit determination, including copies of any relevant payment policies, notices from Highmark publications such as *PRN Policy Review and News*, and other supporting documentation.

The letter also will describe your rights to challenge the results of the audit. You are permitted to send additional information that may help justify or explain any services that were determined to be discrepant. During this time, it may be possible to negotiate a mutually acceptable resolution. If so, you will want to make sure to get a full release protecting you from further liability for the claims or issues involved during the audit period.

If you are unable to resolve the dispute by agreement, you may request a hearing in front of Highmark's Medical Review Committee.

The MRC Hearing

You have the right to submit any outstanding dispute to Highmark's Medical Review Committee (MRC), which currently consists of 10 allopathic physicians, one osteopathic physician, two chiropractors, one physical therapist and two consumer representatives. All of the members attend the hearings and participate in the discussions, but only the practitioner members have a vote.

The hearings are conducted in two locations simultaneously, linked by video conferencing. About half the committee members are present at Highmark's Pittsburgh headquarters at Fifth Avenue Place, and the others are at their site in Camp Hill, Pa.; you can appear at either location. Prior to the hearing, each committee member receives a CD-ROM containing the entire file including any additional information you submit for their consideration, and these documents are displayed at the hearing on a second video screen.

You may be represented by an attorney at the hearing, and you also may present witnesses. If you have engaged a consultant to review your charts, you may want to have your consultant appear as a witness to describe his or her analysis supporting your coding decisions. You also may want to bring a medical expert witness to address issues of medical necessity.

In the hearing, one of the medical directors will briefly present the basis for the overpayment determination, and then you present your case. The committee members may ask you or your witnesses questions during the hearing.

After the testimony, the committee members will deliberate and reach a decision which is communicated to you some time after the meeting. They usually schedule multiple

Governor Corbett Proposes Medicaid Expansion Alternative

By William H. Maruca

In March of 2013, we reported that Pennsylvania Governor Tom Corbett had rejected the option to expand Medicaid eligibility under the Affordable Care Act. In his announcement, he asked the Obama administration to consider approving state-specific alternatives.

On September 16, Governor Corbett announced his proposal to reform Medicaid and increase access to health care in Pennsylvania, under a comprehensive plan entitled "Healthy Pennsylvania."

If accepted by the Obama administration, the plan would establish a hybrid system under which certain low-income individuals who do not currently qualify for Medicaid would be offered access to private insurance coverage using federal funds otherwise earmarked for state Medicaid expansion.

The Medicaid Reforms Proposed Include:

- Simplification of 14 outdated, complex benefit designs;
- Improving personal accountability by eliminating most copays and replacing them with an income-based premium subject to credits for participating in wellness programs;
- Applying work search requirements and a link to job training opportunities;
- Providing a safety net for the critical care for children, older Pennsylvanians and persons with disabilities;
- Improving access and quality of care; and
- Continually emphasizing the reduction of waste, fraud and abuse in all facets of service delivery.

Access would be increased by implementation of a private option program for uninsured individuals currently not eligible for Medicaid with incomes between 0 and 133 percent of the federal poverty level. Coverage would be offered through the federal health insurance exchange.

The program has been compared to proposals on the table from Iowa and Arkansas. The plan will need to be approved by both the Pennsylvania General Assembly and the CMS. CMS has promised to work with Pennsylvania to get the proposal turned around as quickly as possible. The first meeting with CMS was held on September 23, 2013 and a series of public hearings were held by the Department of Public Welfare beginning on January 3, 2014. If approved by CMS, the proposal would take effect in 2015.

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hearings on the same day and do not always make their decisions immediately, so you may not get the results for a while.

The MRC is considered to be contractually binding arbitration, which means it is generally not subject to challenge in court unless you can show some misconduct or fraud on the part of the committee.

The Hearing Determination

The MRC will report its findings to you after the hearing. In most situations, this is the end of the process and you must either pay the amount determined or it will be withheld from future payments. If you have

been thorough and attentive to detail in your responses, it is hoped that this will be a resolution you can live with.

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About the Health Law Practice

Fox Rothschild's Health Law Group comprises more than 40 attorneys who counsel clients locally, regionally and nationally. Our multioffice, multidisciplinary approach allows us to offer practical, cost-effective solutions to issues faced by longstanding stakeholders, as well as a variety of industry newcomers.

For more information about any of the articles in Staying Well Within the Law, please contact any member of the Fox Rothschild Health Law Practice. Visit us on the web at www.foxrothschild.com.



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