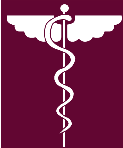
Volume 5, No. 2 Fall 2006

MEDICAL/LEGAL NEWSLETTER



Published by the Onondaga County Medical Society and Wood & Smith, P.C.

A publication for members of the Onondaga County Medical Society

COURT SAYS CARDIOLOGIST MAY PROCEED WITH ANTITRUST CLAIM AGAINST COMPETITORS

Under the Sherman Antitrust Act, conspiracies in restraint of trade are illegal. Many cases have been brought against hospitals and members of their medical staff alleging violations of the Sherman Act when a physician has been kicked off the medical staff, refused certain privileges, or prevented from performing certain procedures due to another group holding an exclusive contract.

These cases usually fail for two reasons: First, it must be shown that the conspiracy in restraint of trade has reduced competition in the marketplace. The emphasis is on injury to *competition*, and not to the individual *competitor*. A disgruntled competitor does not, without more, have legal standing to challenge an illegal restraint of trade. In addition, the complaining physician must establish a combination or some form of concerted action between at least two legally distinct economic entities. If physicians who have engaged in anticompetitive behavior are employed by the hospital, the courts will usually consider them part of a single entity, thus eliminating any conspiracy theory.

"[T]he court said that Dr. Reddy had stated a sufficient case that competition had been reduced for these cardiac services resulting in harm to the general public and not merely to himself as a competitor of Drs. Puma and Sacchi."

Occasionally, a physician is successful is overcoming the first major hurdle of an antitrust case – surviving a motion to dismiss. This year there were two notable antitrust cases decided in New York. Reddy v. Puma, decided on September 19, 2006 by the US District Court for the Eastern District of New York, is one such case and provides us with an illustration of an antitrust case that *might* succeed at trial.

Dr. Reddy is an interventional cardiologist who was instrumental in developing a combined cardiac surgery and interventional program at New York Methodist Hospital. In September 2003, Methodist demoted him from chief of the cardiology division to chief of clinical cardiac services. Shortly thereafter, Dr. Sacchi was named chief of the cardiology division and Dr. Puma was named director of the catheterization lab.

After this change in staffing, Dr. Reddy alleges that he and his partner (Dr. Kassotis) began to experience interference with their efforts to practice at Methodist – a pattern of exclusionary behavior, including discouraging certain physicians at Methodist from referring patients to Dr. Reddy and Dr. Kassotis. Among the allegations of illegal conduct:

- Dr. Sacchi ordered Drs. Reddy and Kassotis to be removed from general cardiology rounds at Methodist's residency program, thus hindering their contact with physicians who were a potential source of referrals.
- Either Dr. Sacchi or Dr. Puma falsely informed a pharmaceutical company that Dr. Reddy was no longer on staff at Methodist.
- Dr. Puma allegedly instructed several physicians' assistants at Methodist, who were assigned to the angioplasty program, not to provide post-operative care to Dr. Reddy's patients.
- Manipulation of the catheterization lab schedule in a way that limited Dr. Reddy's access and forced him to cancel office hours.

Continued on Page 2

INSIDE THIS ISSUE:

Court Says Cardiologist May Proceed With AntiTrust Claim Against Competitors	1
New Mandatory Provider Compliance Program For Medicaid Providers	3
Deferred Compensation Plan Compliance Required in 2007	3
New Health Plan Reforms: Something Is Better Than Nothing	4

NEW MANDATORY PROVIDER COMPLIANCE PROGRAM FOR MEDICAID PROVIDERS

On July 26, 2006, Governor Pataki signed into law comprehensive legislation affecting many types of providers under the Medicaid program. The law codifies and expands the Independent Office of Medicaid Inspector General and creates a new criminal statute entitled "Health Care Fraud".

Certain providers who wish to participate in the Medicaid program must adopt an effective compliance program. The regulations to be adopted under the new law will specify which providers are covered, but the legislation states that it will include any provider for which Medicaid is a "substantial portion" of their business operations. It's unclear what is meant by "substantial".

Unlike the Voluntary Federal Compliance Program issued by the Health and Human Services Office of Inspector General with which many providers are familiar, the program established by this legislation is mandatory.

> **"The creation of a new statutory crime of "Health Care Fraud" would seem to indicate that the State will become much more aggressive with criminal prosecutions against providers who knowingly and willfully engage in improper billing practices with both private insurers and Medicaid."**

However, if a compliance program complies with the standards of the HHS OIG compliance program, it will satisfy New York requirements. In addition, the New York Medicaid Inspector General is directed to create and make available guidelines which include a model compliance program.

Each provider that is required to implement a compliance program that is appropriate for its size and complexity. At a minimum, the program must include (1) written policies and procedures, (2) compliance officer, (3) employee training, (4) clear lines of reporting, (5) disciplinary policies, (6) a system of monitoring, (7) a system for responding to compliance issues, and (8) a policy of non-intimidation and nonretaliation.

The effective date of the mandatory compliance program provisions is January 1, 2007. After that, new providers enrolled in the Medicaid program must certify to the Department of Health that they satisfactorily meet the requirements for an effective compliance program.

If the Department of Health or Medicaid Inspector General finds that a provider does not have a compliance program within 90 days after the effective date of the regulations, the provider may be subject to sanctions or penalties, which may include exclusion from participation as a Medicaid provider.

The creation of a new statutory crime of "Health Care Fraud" would seem to indicate that the State will become much more aggressive with criminal prosecutions against providers who knowingly and willfully engage in improper billing practices with both private insurers and Medicaid. Historically, prosecutions had to fit within the Penal Law provisions that would apply to many different kinds of fraud, including garden variety larceny cases. Depending on the number of fraudulent acts committed and the amount of money obtained by the provider from the health plan, the crimes will range from Class A misdemeanors all the way up to Class B felonies.

The new criminal law is intended to target the physicians under whose name the services are billed. It specifically relieves of responsibility any employee or billing clerk who was just following instructions from the physician or owners of the medical practice.

Deferred Compensation Plan Compliance Required in 2007

Starting in 2007, medical practices will need to make sure that nonqualified deferred compensation plans comply with new regulations enacted under Section 409A of the Internal Revenue Code.

The new regulations will make all nonqualified deferred compensation taxable in the year in which it is earned unless certain requirements are met. This could cause some physicians to incur income taxes on deferred compensation that is not actually received by them, plus a 20% excise tax.

The regulations will also apply to severance compensation paid to a physician upon termination or retirement. However, with careful planning it should not be too difficult for most medical practices to comply if the events triggering the severance are strictly limited and the payment arrangement cannot be accelerated.

NEW HEALTH PLAN REFORMS: SOMETHING IS BETTER THAN NOTHING

On January 1, 2007 amendments to New York's Insurance Law and Public Health Law take effect which will assist physicians in their dealings with health plans. In the bill jacket accompanying the legislation it was noted that the legislation sought to address some of the "numerous difficulties" faced by physicians in their dealings with health plans. The description of the difficulties perceived by the legislature is worth noting:

> "Inconsistent and cumbersome procedures cause physicians to waste valuable resources dealing with the administrative burdens of health care plans, rather than treating patients. These problems include deviation from nationally accepted claims coding standards, confusing health plan rules used to adjudicate claims submitted by physicians, excessive demands for refunds of claims paid several years in the past, the lack of meaningful notice to physicians of refund claims, and unjustifiable delays by health plans in the applications of physicians and other health care providers to participate in the network of such plan."

Which Health Plans are subject to the Law? HMOs and insurance companies. Self-insured plans are not covered.

Claims Processing Transparency. Health plans must use the American Medical Association's CPT codes as well as the CMS' HCPCS coding system when processing health care claims submitted by a physician. Health plans also are required to publish on their websites and in newsletters the name of the claims editing software that the plan uses and any significant edits to the software. The same information must be provided at the written request of a participating physician.

Limitations on Overpayment Recovery.

- Health plans must provide 30 days written notice to a physician before attempting to recover an overpayment. The notice must provide, among other information, a "reasonably specific" explanation of the proposed adjustment. The 30 day notice requirement does not apply to recoveries of duplicate payments.
- The time period for health plans to demand a refund is reduced from six years following payment of a claim to two years. Health plans may not demand refunds more than 24 months after the original payment was received by a physician. However, no time limit would apply when there is reasonable belief of fraud, other intentional misconduct or a pattern of abusive billing; where the recovery is initiated at the request of a self-insured plan; or where it is required by a state or federal government program. In addition, the health plan can look back beyond 24 months to defend a claim by a physician that the health plan has underpaid claims during the same period.
- The limitations on overpayment recovery only apply to overpayment demands made on or after January 1, 2007. Demands made by a health plan prior to January 1, 2007 are unaffected by the legislation.
- This legislation will not affect more favorable provisions in a contract with a health plan. For example, in the Excellus Class Action Settlement Agreement there is a 24 month limit on overpayment recovery between January 12, 2006 through July 11, 2007 which is reduced to 12 months from July 12, 2008 through July 12, 2012.

Credentialing Decisions

Health plans must complete credentialing reviews within 90 days following receipt of the completed application. Limited exceptions are provided where the credentialing process cannot be completed despite the health plan's best efforts; there is a failure of a third party to provide the necessary documentation or unusual circumstances requiring additional time for review.

Although this legislation does not address all abuses by health plans, it represents a good start. Almost as important as the reforms adopted is the recognition by the legislature of the need to assure fairness, uniformity and consistency in the dealings between physicians and health plans.

Wood & Smith, P.C. represents physicians, physician organizations and other health care providers on regulatory, business, real estate and tax matters. Our mission is to help our clients plan for and respond to the challenges and opportunities that exist in the health care industry.

WOOD & *SMITH*, P.C.
ATTORNEYS AT LAW
One Lincoln Center, Suite 1110
110 West Fayette Street, Syracuse, New York 13202 (315) 423-0400 Fax: (315) 424-1011
Visit our Website at woodsmithlaw.com

Medical/Legal Newsletter is a publication of the Onondaga County Medical Society and Wood & Smith, P.C. It is not intended to be used as a substitute for legal advice.

COURT SAYS CARDIOLOGIST MAY PROCEED WITH ANTITRUST CLAIM AGAINST COMPETITORS

Continued from Page 1

In August 2004, Dr. Reddy resigned from his position as Methodist's chief of clinical cardiology, but retained his admitting privileges. He then opened an independent cardiology practice with offices in Staten Island and Brooklyn. It is alleged that the anticompetitive behavior of the defendants continued even after Dr. Reddy resigned from Methodist, including presentations given by Dr. Puma to the Methodist administrative and medical staffs in which he misrepresented Dr. Reddy's rates of complications. In response to those presentations, a committee was appointed to investigate Dr. Reddy's performance. Although the investigation found that there were no quality issues with Dr. Reddy, he suffered a reduction in his base of referrals and consultation volume from Methodist doctors. Finally, he was dropped from New York magazine's "Best Doctors" list, losing referrals from physicians outside the Methodist community.

The court held that although Drs. Puma and Sacchi are employed by Methodist, they have independent and competing economic interests from Methodist. Moreover, the court found that the complaint had properly alleged an injury distinct from Dr. Reddy's private practice, i.e., that assuming the truth of Dr. Reddy's allegations (which the court must do for purposes of a motion to dismiss the complaint) the defendants' conduct reduced the availability and number of providers in interventional cardiac services and caused a demonstrable decline in the quality of patient care. Therefore, the court said that Dr. Reddy had stated a sufficient case that competition had been reduced for these cardiac services resulting in harm to the general public and not merely to himself as a competitor of Drs. Puma and Sacchi.

Another recent conspiracy antitrust case in New York which survived a motion to dismiss is N.Y. Medscan LLC and Karolyn Kerr, M.D. v. New York University School of Medicine and Andrew Litt, M.D. Medscan had a contract to provide the "technical component" (facilities and equipment) of PET/CT scans for NYU radiologists. Medscan became a CareCore approved facility. CareCore is a radiology benefit management company with over 22 million subscribers, including 3.5 million subscribers in New York City, so it had substantial control in the marketplace. One of the original defendants, Dr. Litt, was both a board member of CareCore and the vice-chairman of financial affairs for NYU Medical School.

Medscan also entered into a practice management contract with another CareCore approved radiologist, Dr. Kerr. During negotiations between Medscan and NYU for the renewal of their 3-year contract, Dr. Litt allegedly told Medscan that if it didn't agree to NYU's renewal terms, then Medscan and Dr. Kerr would lose their CareCore approvals. Specifically, Litt advised Medscan executives, in words or in substance, "I am CareCore" and asked Medscan representatives "how are you going to do this business without me? When Medscan did not agree, CareCore terminated Medscan's and Dr. Kerr's approved provider status. Thereafter, CareCore refused to precertify or pay for services provided by Medscan and Dr. Kerr.

Medscan sued NYU and Dr. Litt alleging that they illegally conspired to suppress competition in New York City for PET/CT services. The court refused to dismiss the case, holding that the plaintiffs had sufficiently alleged an antitrust injury, i.e., that the conduct of the defendants had harmed competition and caused a decrease in the quality and availability of services for PET/CT.

The evidence of a conspiracy was demonstrated by the fact that Dr. Litt served in two capacities – as an owner of CareCore and as an executive of NYU.

Despite the fact that the plaintiff's case survived the motion to dismiss, the court acknowledged that the federal courts have repeatedly rejected the antitrust claims of disappointed physician competitors who were excluded from exclusive contracting arrangements, denied participation in managed care arrangements, or otherwise excluded from business opportunities.

The court further noted that exclusive contracts, such as the ones at issue in this case, are an essential part of reducing prices for managed care providers, and, "if analyzed from the standpoint of its effect on competition rather than its effect on competitors with whom the [managed healthcare] plan refuses to contract, selective and exclusive contracting should raise significant antitrust issues infrequently."

WE HAVE A NEW WEBSITE

Visit us at:

www.woodsmithlaw.com