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Late breaking news on medical-legal developments affecting physicians and health care professionals

Federal Appeals Court Rules on Antitrust Issues in Hospital Medical Staff Case: In an opinion issued on August 20, 2015, the United States Court of Appeals for the Third Circuit ruled, in *Novak v. Somerset Hospital*, that a physician who brought an antitrust case against Somerset Hospital in Somerset, Pennsylvania, the hospital's CEO and two other physicians, arising from the termination of his medical staff privileges, which the Hospital alleged had occurred due to the plaintiff's performance to two unauthorized surgeries, had failed to establish an antitrust injury. The Third Circuit affirmed the order of the U.S. District Court for the Western District of Pennsylvania granting summary judgment to the defendants. The plaintiff contended the hospital had illegally restrained patient choice for general surgical services in Somerset Hospital. As a threshold issue, in order to state such a cause of action under the antitrust laws, the plaintiff had to demonstrate that the defendants effectively prevented him from practicing in a properly defined marketplace. In antitrust law, this is known as the "relevant market." Relevant market includes both a product market and a geographic market. The plaintiff argued the product market consisted of general and gastrointestinal surgery services and the Court found there was another hospital in the area where the same surgeries were performed. Similarly, as the relevant geographic market also included this other hospital, the plaintiff could not show his loss of privileges at Somerset Hospital prevented him from treating patients in this market.

ICD-10 Conversion Finally Here: After three previous delays in implementation, it appears the changeover to the ICD-10 diagnostic and procedural coding system is finally here. The new deadline for implementation of ICD-10 is October 1, 2015 and further delay of implementation appears extremely unlikely. Although hospitals and large group medical practices may see some cash flow problems due to ICD-10 payment delays, it is expected that these larger entities should be able to weather the proverbial storm. However, physician organizations have stated smaller practices may have much greater difficulties in surviving any payment slowdowns. One area of concern is the levels of compliance among state Medicaid programs. CMS has allowed four state Medicaid programs, in California, Louisiana, Maryland and Montana, to use a "workaround" where ICD-10 codes will be converted back to ICD-9 before they are processed. A recent MGMA survey found that 9.2% of physician groups were still using electronic data transmission formats which are incapable of carrying ICD-10 codes. Another possible area of concern is reduced employee productivity caused by the switchover, including assigning codes under ICD-10, which may take additional time to correlate and cross-check. Although CMS has agreed to a degree of flexibility with respect to provider submission of ICD-10 codes, the same may not be true with respect to private insurers.

Recent Federal Healthcare Fraud Actions: The U.S. Attorney for the Eastern District of New York announced a physician, following a guilty plea, was sentenced to 24 months in prison for healthcare fraud conspiracy for his role as a "no show" doctor in a $13 million scheme. As part of the sentence, the doctor will pay more than $6.4 million in restitution and forfeit more than $6.5 million. The physician served as medical director of a health care clinic in Bensonhurst and admitted that from 2009-2012 services at the clinic were provided by a physician assistant who acted without supervision by a medical doctor, and the clinic billed Medicare and Medicaid for the services under the physician's billing number. The physician also admitted to falsely certifying that transportation by ambulette was medically necessary. On the civil side, the U.S. Attorney announced that two physicians in the same group practice in East Islip have entered into separate civil settlement agreements in which they have collectively agreed to pay the U.S. government more than $1.1 million to resolve allegations they submitted claims to Medicare for nerve conduction studies (NCVs) that were not medically necessary. The government alleged the NCVs were ordered despite the lack of indications in the medical charts, and where indicated, were not performed accordingly (for example, the government alleged patients with arm complaints were given leg studies). The investigation leading to the settlement agreements began after a receptionist in the medical practice filed a *qui tam* complaint under the federal False Claims Act on behalf of the United States. The government intervened in the lawsuit.

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