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ANTITRUST IN PROVIDER NEGOTIATIONS

By Grant W. Peters

The Federal Trade Commission (“FTC”) is charged by Congress with protecting the public against anti-competitive behavior. The FTC recently reported that it has 35 lawyers and investigators who work exclusively on health care antitrust matters. The FTC legal staff has a substantial track record of antitrust actions against providers. Physicians, physician groups, pharmaceutical and device manufacturers, clinics, and hospitals have all felt the impact of FTC enforcement actions.

Formation of a group of providers large enough to potentially impact the cost of health care services in the group’s local area can be enough to invite FTC review. Where the providers actually work together to establish the prices or terms they will require for their services, there is a greater risk that the activities will be considered anti-competitive. The FTC is very interested in market power - the ability of the entity to raise prices or set terms. In numerous antitrust actions, the FTC has alleged that health care costs increased as a result of the formation of the offending entity or association. The FTC frequently relies on various economic tests when it analyzes market power.

In a 2005 case, two physician groups providing orthopedic services in the Cincinnati, Ohio Metropolitan area formed an independent practice association called New Millennium Orthopedics (“NMO”), to jointly negotiate the rates the groups would charge health plans. This “horizontal” integration allowed the two groups to continue to operate separately, apart from their joint contracting activities through

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Grant W. Peters, M.D., J.D.



Over 20 Years in Health Care Profession

Grant W. Peters, M.D., J.D. is a graduate of Loma Linda University where he received his degree in Chemistry and his M.D. He earned his juris doctorate at Boalt Hall School of Law, University of California, Berkeley. He also holds an M.S.A. in Healthcare Administration.

His legal practice at Borton Petrini LLP has been enhanced by his hands-on experience in the medical field. Grant has worked as an Associate Hospital Administrator for Professional Services; Chairman of the Department of Anesthesiology; Board of Directors/Governing Body Member; and President of a specialty physician group.

To stay abreast of the ever-changing legal field, Grant is a member of the Health Law Section of the American Bar Association and a Fellow of the American College of Legal Medicine.

Grant is available to provide legal services related to health care law.

SELECTED APPELLATE DECISIONS CONCERNING THE HEALTH CARE INDUSTRY

By Dee H. Stasnopolis

Prospect Medical Group v. Northridge Emergency Medical Group (2006). The plaintiffs in this case were affiliated medical groups that provided services for a health care service plan. The defendants were emergency care providers who had not contracted to provide emergency care to the health care plan's subscribers. When the emergency providers treated health plan patients, the medical groups often paid the emergency providers less than their charges, based upon the medical group's view of what was a reasonable charge. When not paid in full, the emergency providers billed the patients for the difference, a practice known as "balance billing." The medical groups sought review of a lower court decision favoring the defendants.

Health and Safety Code section 1379 prohibits contracting providers from billing patients for charges not paid by the patient's managed care plan. The appellate court held that the statute did not prohibit balance billing in the absence of a pre-existing contractual relationship; the statute applied only when there was a written contract. The court further held that the reimbursement requirement of Health and Safety Code, section 1371.4 gave the medical groups standing to contest the reasonableness of the emergency provider's rates, but the medical groups were not entitled to a judicial determination imposing Medicare rates as a "reasonable rate" on the emergency providers. The court remanded the matter to the trial court for further proceedings.

Lieblein v. Shewry (2006). Plaintiff, a pharmacist, was denied continued enrollment as a Medi-Cal pharmacy provider. The pharmacist's application, which had been signed under penalty of perjury, incorrectly stated that he had never been subject to any disciplinary action by the Board of Pharmacy. The application was denied by the Department of Health Services pursuant to Welfare and Institution Code, section 14043.2, for failure to disclose professional discipline. The pharmacist asserted that the incorrect statement was inadvertent and that one of his employees had filled out the application for him. The pharmacist appealed the Superior Court's denial of his Petition for Writ of Mandamus challenging the Department's denial of his application.

The court, in affirming, held that the Department

was not required to establish that a provider's false statement in an application was intentional, willful, or fraudulent, before the Department could impose sanctions. The sanctions followed from violation of the disclosure provision per se and they applied equally to new and existing applicants. Therefore, due process did not require an evidentiary hearing with live testimony. Written evidence was sufficient in an administrative appeal to affirm the Department's determination.

Thornburg v. Bactes Imaging Solutions (2006). The petitioner patient had sued Bactes Imaging Solutions for violations of Evidence Code, section 1158, which sets the maximum allowable charges for copying medical records at a patient's request. In this case, the hospital had entered into an agreement with Bactes Imaging Solutions to perform the task of producing copies and billing. Under the terms of the agreement between Bactes and the hospital, Bactes was responsible for producing

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20 Years Experience in Health Care Law



Dee H. Stasnopolis is a Partner in the Bakersfield office of Borton Petrini, LLP. Dee graduated from Southwestern School of Law in 1982. In addition to his admittance to the State Bar of California, he is admitted to practice before the U.S. Supreme Court, the Ninth Circuit Court of Appeals and all Federal District Courts for the State of California.

His areas of specialty at Borton Petrini, LLP involve commercial health care litigation, health care law, and medical malpractice.

Dee is a member of the Kern County Bar Association, as well as the State Bar of California. His professional involvement also has included instructing insurance companies on settlement tactics, conducted legal-liability assessments for companies and has served as an arbitrator for the Los Angeles and Kern County Superior Courts. Dee has handled numerous cases involving medical malpractice, commercial health care disputes and other medical compliance issues. He is also a member of the DRI Section on Health Care Law.

copies and billing for the copies. Bactes also agreed to indemnify the hospital for any claims associated with the copying activity. The agreement between the hospital and Bactes did not limit copying fees or require the agent to account for copying fees. The Superior Court sustained the defendant's demurrers without leave to amend.

The court noted that agents generally were not liable for statutory duties imposed on their principals. This protection could be lost, however, when an agent acted for the agent's own benefit rather than solely on behalf of and at the direction of the principal. Accordingly, the court concluded that Bactes could be held liable under the statute if they had assumed the duty of responding to Evidence Code, section 1158 requests and they were acting for their own advantage and benefit as well as the interests of entities expressly covered by the statute. The court, therefore, reversed the trial court's determination and remanded the matter back to the Superior Court for further handling.

Cedars-Sinai Medical Center v. Shewry (2006). Plaintiff, Cedars-Sinai, was a provider of medical services to Medi-Cal beneficiaries. Audits by the director of the California Department of Health Services determined that Cedars-Sinai owed \$35 million to reimburse the State of California for overpayments. Cedars-Sinai had been working under a delegation amendment to the Medi-Cal contract with UCLA. Instead of billing at the UCLA contract rate, Cedars-Sinai billed and was paid more for certain patients. Following the audits, the Department of Health Services demanded recoupment for the overpayments.

The appellate court held that a provider was not entitled to judicial review under Welfare and Institutions Code, section 14087.27 prior to administrative hearings. Further, the court determined: that Cedars-Sinai had failed to raise contract interpretation claims when the issues first arose and so could not raise them during the administrative hearing proceedings; that Cedars-Sinai was limited to the UCLA contract rate for treatment of the Medi-Cal patients under the contract; and, that the audits were timely under Welfare and Institution Code, section 14170. However, because the Department did not adopt the proposed decision pursuant to Welfare and Institutions Code, section 14171 within 300 days after the closure of

the administrative record, a (10%) penalty reduction on the total recoupment claim was imposed.



ANTITRUST IN PROVIDER NEGOTIATIONS

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NMO. After the FTC sued, the providers ultimately agreed to a consent order that called for the dissolution of New Millennium. The consent order also prohibited the two physician groups from entering into any agreements that would restrict the ability of any physician to deal with any health plan individually.

In a 2003 case, Surgical Specialists of Yakima was formed to allow several physician groups to deal together with health plans. Again, the groups remained otherwise economically and clinically independent. Because of the lack of integration and the large market share held by the two surgical practices, the FTC alleged violation of the antitrust regulations. The physicians ultimately agreed to a consent order. The groups were prohibited from negotiating or otherwise agreeing to any terms for dealing with payers and from exchanging information concerning payer contracting.

Physicians and other providers need to be mindful of the antitrust regulations when negotiating for prices, fees, and other terms with payers such as HMOs. Fully integrated groups, with both clinical and economic integration, have much more leeway to negotiate on behalf of the physicians than do partially-integrated groups, such as cost sharing or joint contracting arrangements. Physicians should be particularly concerned about any arrangements with other physicians outside of an integrated group practice, particularly where those agreements might be perceived as somehow affecting the cost of medical services. Providers contemplating formation of new entities or arrangements with other providers should obtain the advice of legal counsel. Potentially problematic existing arrangements should be also be reviewed.

The FTC is proud of its enforcement of the anti-trust laws enacted by Congress. Providers would do well to structure their business relationships to avoid being caught in the FTC's enforcement cross-hairs.



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