

# California and National News

## **Incredible Billings and Reimbursements Brought to Public Notice:**

Aetna has lawsuits pending against six physicians in New Jersey for medical bills that the insurer calls “unconscionable.” Allegedly, \$57,000 was billed by an out-of-network cardiologist for a bedside consultation for a noncritically ill patient for which the physician previously had charged \$220, and \$59,000 for an ultrasound examination for which Aetna routinely reimburses in-network physicians \$74! Moreover, the same cardiologist allegedly charged \$56,600 for an out-of-network cardiac catheterization.



He allegedly also raised his charges for cardiac stress tests tenfold over a two-year period, and sevenfold for electrocardiograms.

These allegations bring into focus the issue of what pricing limits, if any, insurers can impose on “out-of-network,” noncontracted physicians. Another example was an alleged charge for a cesarean delivery of \$30,000 (ten times more than the allowed in-network reimbursement). That physician reportedly received \$5 million from Aetna in 2010, a fourfold increase from the \$1.4 million of the previous year. And yet another physician, an internist, allegedly billed \$9,000 for a critical care consult, a dramatic increase from \$500 he billed for the same service a year previously, and almost 50 times the meager amount paid by Medicare. Aetna claims it paid him almost \$4 million in 2009, twelve times more than in 2008.

Aetna alleges that the defendant physicians violated the New Jersey Board of Medical Examiners’ rules against excessive billings, and is seeking triple damages under the state insurance fraud laws prohibiting filing false or misleading claims. Note that Aetna’s net income for 2010 increased 38 percent to \$1.77 billion!

Have these physicians committed unethical acts? Should consumers and purchasers of health insurance be outraged? Should one consider the injustices and avariciousness associated with insurers’ refusal to reimburse what ethically and morally bound physicians would consider fair and reasonable compensation? And, should one consider the egregious inadequacies of the “physician networks” provided by insurers? Are those inadequacies the result of the unwillingness of insurers to appropriately and justly reimburse physicians, knowing that they cannot “collectively bargain”? What should the just and reasonable reimbursement figure be? Who determines such, and how is it arrived at? Have the carriers calculated that it is more profitable, immorality

aside, to bully the large majority of physicians whom they “control” (under the cover of the federally illegal status of collective bargaining) into submitting to egregiously low reimbursements, while acceding to the outrageous demands of the few physicians who are bold enough to charge equally immoral huge fees?

The chief medical officer of Health Advocate Inc. (Pennsylvania) asks whether greedy carriers will ever agree to offer physicians an “acceptable, unbiased judgment as to what a reasonable and customary reimbursement rate is?” Why is there no successful outcry against insurance companies’ excessive profits (for their executives and shareholders) that are extracted from physicians and hospitals? How immoral is it for these insurers to retain such large percentages of health care premiums for profits, monies that never are employed for the care of their insureds? Indeed, we have a broken health care system even for the insured, not to mention the dilemmas faced by the uninsured.

In 2007, New Jersey physicians complained to the New Jersey Department of Banking and Insurance about Aetna’s imposition of caps on some out-of-network reimbursements. The physicians prevailed, and Aetna was fined \$2.5 million and ordered to pay out-of-network physicians enough to supposedly protect patients from being balance-billed beyond co-pays. In 2009, the attorney general of New York investigated Aetna, United Healthcare, Cigna and WellPoint for underpaying out-of-network physicians by manipulating a database used to calculate payments. Aetna settled for \$90 million and United Healthcare had to pay \$350 million!

*Adapted with commentary from article by Peter Waldman, Bloomberg Report, 2011.*

**Thirty Doctors Subpoenaed in Probe of Surgery Center Entrepreneur/Acquaintance of Rod Blagojevich and Jesse Jackson, Jr.:** A federal grand jury has subpoenaed numerous “doctors” in the greater Chicago area as part of an FBI and IRS probe of a prominent political fund-raiser, Raghuvver Nayak, who owns surgery centers in both Illinois and Indiana and, interestingly, has been connected with former Gov. Rod Blagojevich and U.S. Rep. Jesse Jackson, Jr. Illinois state campaign records indicate that surgery centers linked to Nayak contributed more than \$283,000 to Illinois politicians between 2001 and 2007, including \$174,000 to impeached ex-Governor Blagojevich. The nonphysician entrepreneur may have made improper payments to “doctors” (including podiatrists and chiropractors as well as physicians) in order to entice their business to his 12 surgery centers and satellite offices. While private insurers paid the “doctors” and centers for their services, Nayak allegedly separately paid hundreds of thousands of dollars to the “doctors” for the patients delivered to the centers. Some of the “doctors” have been offered

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or granted immunity for their testimony, and therefore would be protected from criminal prosecution, but their licenses to practice could be at risk, as the Illinois Medical Practice Act permits suspension or revocation of state licenses if the “doctors” engage in “dishonorable, unethical or unprofessional conduct ... or share or split any professional fee or other source of compensation for professional services with anyone in exchange for a referral.” Nayak allegedly did not receive any federal funding at the centers.

Nayak allegedly is a fund-raiser for—and donor to—Jackson. Allegedly, in 2008 Nayak, cooperating with authorities, told investigators that then Representative Jackson had asked him to approach then Governor Blagojevich with a \$6 million offer of campaign money in exchange for a Senate seat appointment. Blagojevich’s brother allegedly testified that he had been the person approached and turned down the \$6 million offer. However, a Blagojevich appointee, Rajinder Bedi, accused Nayak of laundering hundreds of thousands of dollars through him in an alleged check-cashing scheme.

*Adapted from an article by Natasha Korecki and Dave McKinney, Chicago Sun-Times, April 12, 2011.*

### **Sutter Health Accused of Fraudulent Anesthesia Billing Practices:**

A whistle-blower lawsuit recently joined by the state of California alleges that the nonprofit health network Sutter Health has engaged in fraudulent billing practices for anesthesia services by submitting third-party payors with “false and overblown bills.” The amount of this alleged fraud runs in the hundreds of millions of dollars over the past decade. The intervening motion filed in California Superior Court by Insurance Commissioner Dave Jones alleges that Sutter Health commonly charged as much as \$5,000 for anesthesia services that should have qualified for a reimbursement of approximately \$250. According to the motion, the “charges so far exceed actual costs that it is clear Defendants are actually double billing for costs captured in the anesthesiologist’s bill or in other revenue codes, or are simply billing for services not actually provided.” The suit was initially filed in 2009 by health care auditor Rockville Recovery Associates against Sutter Health and co-defendant Multiplan, Inc. (a third-party company), after it allegedly uncovered billing discrepancies while conducting an investigation requested by Guardian Life Insurance of America.

Sutter Health denies the allegations and claims that the supposedly high billings reflect the costs of meeting California’s earthquake retrofit regulations, advances in technology, and treating patients who could not afford health care insurance. Moreover, Sutter claims that because the reimbursement rates reflect negotiated contracts with health insurers, they should not be considered to be

fraudulent. However, Jones replied that Sutter Health has clauses in its payor contracts that preclude insurers from challenging the reasonableness of its bills.

*Adapted from an article by Irene Tsikitas, Outpatient Surgery, April 2011.*

**Hospital Suspends Surgeon's Privileges in Portland, Ore.:** Providence Portland Medical Center suspended the surgical privileges of a neurosurgeon, Vishal James Makker, apparently because of his exceedingly high rate of multiple spinal-fusion surgeries, the highest identified in the U.S. for Medicare patients in 2008–2009, and ten times the national average. The surgeon, who operated on some of his patients as many as seven times, claimed that he acted in the best interests of his patients. Both the FBI and Oregon's State Medical Board are investigating this matter. In 2006, the Oregon board forced Dr. Makker to enter remedial training for what it called unnecessary surgeries as well as for allegedly billing for procedures that he didn't perform! But this story involves even greater ethical and moral issues to be addressed because the distributor of the spinal implants, Omega Solutions of Fresno, Calif., allegedly will pay surgeons to use its medical devices. A document reviewed by The Wall Street Journal allegedly revealed that the company enters into partnerships with surgeons who agree to use their devices, and in return pays them "dividends" based on the number of surgeries that they perform. Of further interest, the product representative in Providence Hospital allegedly is a female friend of Dr. Makker. Physician-owned distributorships (PODs) are spreading throughout the spinal surgery community and can help companies secure the business of a hospital as well as feed the coffers of the surgeons. Indeed, there has been a steady increase in spinal surgeries, and the costs for Medicare have increased from \$343 million to \$2.2 billion from 1997 to 2008. As might be expected, both the Office of the Inspector General of the Department of Health and Human Services and the Centers for Medicare and Medicaid Services have indicated that such PODs may violate federal anti-kickback statutes and laws governing patient referrals. Of "local" note, the CEO of Omega Solutions is listed in California corporate records as a partner in several limited liability companies that could possibly be considered to be PODs.

*Adapted from an article by John Carreyrou and Tom McGinty, The Wall Street Journal, April 13, 2011.*