IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

AETNA INC., AETNA HEALTH, INC., AETNA HEALTH MANAGEMENT LLC, AND AETNA LIFE INSURANCE COMPANY, **Plaintiffs,** **v.** **MEDNAX, INC., PEDIATRIX MEDICAL GROUP, INC., AND MEDNAX SERVICES, INC.,** **Defendants.**	**CIVIL ACTION** **NO. 18-2217**

MEMORANDUM OPINION

Plaintiffs are affiliated health insurance companies Aetna Inc., Aetna Health, Inc., Aetna Health Management LLC, and Aetna Life Insurance Company (collectively, "Aetna") which allege that Defendants Mednax, Inc., Pediatrix Medical Group, Inc., and Mednax Services, Inc. (collectively, "Mednax"), affiliated companies that provide management and financial operations services to physician groups, fraudulently inflated insurance claims for services rendered in neonatal intensive care units ("NICUs"). After fact discovery closed, Aetna produced the report of its damages expert, Dr. Michael Cragg (the "Cragg Report"), which calculated damages arising from two sources: (1) the amount Mednax fraudulently induced Aetna to pay Mednax, approximately $58.3 million; and, (2) the amount Mednax fraudulently induced Aetna to pay hospitals in which Mednax physicians practiced, approximately $102.7 million.

Mednax now moves to strike the second damages theory pursuant to Federal Rule of Civil Procedure 37(c)(1). For the following reasons, Mednax's motion will be granted.

I. BACKGROUND

Aetna's suit, for fraud, negligent misrepresentation, money had and received, unjust

enrichment, and civil conspiracy, alleges that Mednax engaged in "a scheme to defraud Aetna" in which Mednax "intentionally and systematically overbilled Aetna" by "fraudulently inflating the severity of the clinical condition of their newborn patients on bills that Mednax submit[ted] to Aetna for reimbursement," and requiring Mednax physicians to "designat[e] infants as being sicker than they truly were so that it appeared as if the infants required more intensive treatment than was truly the case." In support of its allegations, the Complaint relies on a statistical analysis of "tens of thousands of claims submitted by Mednax to Aetna for reimbursement," which the Complaint alleges "shows unequivocally that Mednax billed for services in a manner that far exceeded comparable non-Mednax physician groups" even after "adjust[ing] for or rul[ing] out" factors that could account for the differences in Mednax's billing. Among other factors, the Complaint explains, Aetna "adjusted for or ruled out" the "Severity of [the] Patient's Condition," stating, "Mednax patients' conditions are not more severe than non-Mednax patients, nor did Mednax patients have longer length of stay."

The Complaint alleges that "[u]pcoding and billing of unnecessary tests by Mednax resulted not only in excessive payments to Mednax, but also in inflated payments to hospitals in which tests were performed and NICUs were housed." As a result of Mednax's fraud, the Complaint summarizes, "Aetna has paid more than $50 million more than it should have to Mednax. Aetna brings this action to recover these overpayments."

At the outset of the litigation, as required by Federal Rule of Civil Procedure 26(a)(1)(A)(iii), Aetna disclosed to Mednax its "computation of each category of damages claimed," stating that "[w]ithout limitation, Aetna seeks damages in the amount still to be determined, but exceeding $50 million, representing the overpayments that Defendants fraudulently induced Aetna to make." Mednax proffers without contradiction by Aetna that

Aetna has not served a supplemented version of its Rule 26 damages disclosures.

Following closure of fact discovery Aetna timely served on Mednax the Cragg Report which purports to "calculate the excess payments Aetna paid as a result of Mednax's overbilling for the treatment of newborn children," ultimately calculating that Aetna is owed approximately $161 million from the two sources of damages noted above. First, the Cragg Report focused on Mednax's use of evaluation and management ("E/M") medical procedure codes, which divide medical procedures for newborn patients into four categories: newborn, hospital, intensive, and critical. The Cragg Report found damages of approximately $58.3 million from two forms of E/M code overbilling: (1) "for a NICU stay of a given length . . . Mednax bills more intensive and critical E/M procedures as opposed to less expensive newborn and hospital E/M procedures"; and, (2) "Mednax keeps newborns in the NICU longer on average," which "also results in Mednax billing more E/M procedures." Second, the Cragg Report calculated damages from "extra payments *to hospitals* resulting from the overly long NICU stays for newborns under Mednax's care." The Cragg Report explained, "Aetna's payments to hospitals compensate the hospitals for providing care and resources to the newborn via revenue codes. . . . Since hospital payments are larger the longer a newborn spends in the NICU, Mednax's behavior of extending NICU stays resulted in Aetna paying more to hospitals than it otherwise would." By the Cragg Report's calculations, Mednax's fraud caused Aetna to overpay hospitals $102.7 million.

Mednax now moves to strike this second damages theory as sanction for Aetna's failure to timely disclose it. According to Mednax, not only did Aetna fail to timely disclose that it was seeking damages for the amounts it paid to hospitals, but it also repeatedly denied during fact discovery that it sought such recovery and refused to respond to Mednax's discovery regarding the same. Aetna contends that sanction is unwarranted, citing its broad Rule 26 disclosure, the

Complaint's allegation that Aetna overpaid hospital claims, and Aetna's repeated representations to Mednax that, per Aetna's brief in opposition, it "intended to support its claim with an emphasis on expert reports." As set out below, however, the crux of the instant dispute lies in Aetna's representations during fact discovery that payments made to hospitals were not relevant to the case.

A. Deposition of Richard Harris

During discovery, Mednax requested pursuant to Rule 30(b)(6) that Aetna designate a corporate representative to testify about the damages in excess of $50 million claimed in Aetna's Complaint and initial disclosures, "includ[ing] but [] not limited to the method for calculating those amounts, . . . [and] whether and how Aetna's calculation of its claimed damages has changed since the filing of the Complaint." Aetna objected on, among other grounds, that the request was "overbroad" and "seeks information that is not relevant . . . to the needs of the case." The parties took their dispute to the Special Discovery Master[1] who recommended that Aetna "produce a witness to testify about the basis for the damages figures in its complaint and initial disclosures," but cautioned that "questioning regarding the details of the damages methodology likely would be inappropriate." Aetna designated one Richard Harris as their 30(b)(6) witness who at deposition when asked by Mednax if he was "prepared to offer any testimony" on Mednax's damages, stated in relevant part, "[a]ll I can say is this analysis was prepared by an outside expert. It has been produced. And anything that has not been produced is privileged."

B. Mednax Requests for Production ("RFPs") 108 and 110

During the course of the litigation, Aetna produced a dataset with information for all of Aetna's NICU claims from 2009 to February 2019 (the "August Data"). Mednax subsequently

[1] The Court appointed Bruce Merenstein, Esquire, as Special Master after it became clear that almost every aspect of discovery was to be hotly contested.

served RFPs 108 and 110, seeking more information about the August Data. Specifically, it requested that Aetna produce documents and data related to Aetna's "Clinical Claim Review" and "Utilization Review" – processes in which Aetna monitors, assesses, and authorizes care for insured patients – of claims reflected in the August Data. Aetna objected that such discovery was "overly broad, unduly burdensome, and not proportionate to the needs of the case," and that Mednax "is requesting information that it possesses" because Mednax "is aware of how its claims are adjudicated." It subsequently objected (by way of letter) to production of the documents and data on the grounds that "Aetna does not perform utilization review or clinical review" of physician E/M codes. "[T]hose reviews," Aetna's letter explained, "are focused on facility claims" – that is, claims hospital facilities submitted to Aetna – and "[t]hus, claims at issue in this case will not have been the focus of utilization review or clinical review." Aetna's letter continued, production of "information regarding any time Aetna has reviewed medical records from hospital facilities that somehow implicate care provided [by a] Mednax physician" would be "extremely disproportionate to the needs of the case, and for records that are not relevant to the issues in this matter."[2]

C. Mednax RFPs 103 and 104

Mednax also served RFPs 103, 104, and 107, which requested production of Aetna's policies, guidelines, and procedures for the medical coding of NICU claims and Aetna's review

[2] The record indicates that Aetna did ultimately produce at least some records responsive to RFPs 108 and 110. On July 20, 2020, Mednax requested that the Special Master recommend that Aetna be compelled to produce documents relating to Aetna's review of hospital and physician claims submitted in connection with the medical care of patients Aetna alleged were the subject of "upcoded" Mednax claims. Mednax contended that such records were responsive to RFPs 108 and 110, *inter alia*, and relevant to show whether "Mednax's billing for these patients was appropriate" and "Aetna should have detected (or did detect) the alleged upcoding of these claims earlier," noting that "[w]hile Mednax has information concerning Aetna's final adjudication of claims *it* submitted, it does not have . . . [Aetna's] communications made directly with the hospital facilities." In a letter to the Special Master, Aetna ultimately agreed to produce Mednax's requested materials for four patients, although Aetna explained that it "stands by its objections."

DOCKET ALARM

Explore Litigation Insights

Docket Alarm provides insights to develop a more informed litigation strategy and the peace of mind of knowing you're on top of things.

Real-Time Litigation Alerts

Keep your litigation team up-to-date with **real-time alerts** and advanced team management tools built for the enterprise, all while greatly reducing PACER spend.

Our comprehensive service means we can handle Federal, State, and Administrative courts across the country.

Advanced Docket Research

With over 230 million records, Docket Alarm's cloud-native docket research platform finds what other services can't. Coverage includes Federal, State, plus PTAB, TTAB, ITC and NLRB decisions, all in one place.

Identify arguments that have been successful in the past with full text, pinpoint searching. Link to case law cited within any court document via Fastcase.

Analytics At Your Fingertips

Learn what happened the last time a particular judge, opposing counsel or company faced cases similar to yours.

Advanced out-of-the-box PTAB and TTAB analytics are always at your fingertips.

API

Docket Alarm offers a powerful API (application programming interface) to developers that want to integrate case filings into their apps.

LAW FIRMS
Build custom dashboards for your attorneys and clients with live data direct from the court.

Automate many repetitive legal tasks like conflict checks, document management, and marketing.

FINANCIAL INSTITUTIONS
Litigation and bankruptcy checks for companies and debtors.

E-DISCOVERY AND LEGAL VENDORS
Sync your system to PACER to automate legal marketing.