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REFEREE

SUPERIOR COURT FOR THE STATE OF CALIFORNIA

COUNTY OF SACRAMENTO

STATE OF CALFORNIA ex rel.ROCKVILLE RECOVERY ASSOCIATES, LTD.,

Plaintiffs,

v.

MULTIPLAN, INC., et al.,

Defendants.

Case No.: 34-2010-00079432

JAMS Ref. No.: 1100065416

ORDER ON MOTION OF SUTTER DEFENDANTS FOR SUMMARY JUDGMENT ON SPECIFIC INTENT ELEMENT OF PLAINTIFFS' CLAIM

I. INTRODUCTION

In this case, Plaintiffs, The State of California through the California Department of Insurance ("DOI") and Rockville Recovery Associates Ltd. ("Rockville") bring two claims against the Sutter Defendants: the first cause of action is for violation of the Insurance Fraud Prevention Act ("IFPA"), Ins. Code sec. 1871, *et seq.,* and the third cause of action is for equitable relief based on the same allegations. DOI and Rockville will collectively be referred to herein as "Plaintiffs".

The Sutter Defendants (herein "Sutter") move for an order granting summary judgment in their favor and against Plaintiffs, (herein "Sutter's Motion"). In their Motion, Sutter argues that

violations of the IFPA based on Penal Code Section 550 require specific intent to defraud and actual knowledge of falsity. Sutter argues that it did not and does not believe its billings are false, had no actual knowledge of falsity and never had a specific intent to defraud.

In opposition, Plaintiffs argue that even if they are required to prove specific intent to defraud, which they dispute, Sutter can be held liable if it willfully submitted false, fraudulent, or misleading claims to obtain benefits to which it was not entitled. Plaintiffs argue that Sutter's Motion fails because there are triable issues of fact as to Sutter's knowledge of the falsity of its anesthesia billing.

Sutter's Motion was fully briefed and oral argument was heard before the Special Master in this case, Hon. William L. Bettinelli (Ret.) of JAMS on June 27, 2013, at the JAMS offices in San Francisco.

II. PARTIES

This Motion is brought by the "Sutter Defendants." The "Sutter Defendants" include California health care providers Sutter Health, Sutter Health Sacramento Sierra Region, Eden Medical Center, Sutter East Bay Hospitals, Marin General Hospital, Sutter Coast Hospital, Sutter West Bay Hospitals, Sutter Central Valley Hospitals, Palo Alto Medical Foundation, Sutter Gould Medical Foundation, and Mills-Peninsula Health Services. California Insurance Commissioner's Second Amended Complaint in Intervention, ("SACI"), ¶ 27.

Plaintiff Rockville is a New York based corporation in the business of auditing health care bills on behalf of payers. SACI ¶ 11. Payer, Guardian Life Insurance Company hired Rockville to perform an audit of bills submitted to it, including bills from numerous Sutter hospitals in California. In its role, Rockville had direct access to claims submitted to Guardian. SACI ¶ 12.

The DOI intervened in this action on behalf of the State of California, and under the IFPA, took over prosecution of this case. SACI ¶¶ 3-7.

The operative complaint is the Commissioner's Second Amended Complaint in Intervention, or SACI.

III. THE IFPA AND PLAINTIFFS' CLAIMS

Plaintiffs bring two claims under the IFPA against Sutter. In their first cause of action, Plaintiffs allege that Sutter's billing to insurers for anesthesia is false, fraudulent, and misleading under the IFPA because the bills represent charges for services not provided, for services already charged elsewhere on the hospitals' bills or on anesthesiologists' separate bills to payers, or for costs not appropriately billed chronometrically for the duration of an operating room procedure. SACI, ¶¶ 41, 46-59, 68-82. Plaintiffs seek civil penalties in their first claim. *Id.* at ¶ 82 and prayer. In their third claim, plaintiffs seek declaratory and injunctive relief based on the same allegations. *Id.* at ¶¶ 89-92 and prayer.

The IFPA, codified at Insurance Code §1871 *et seq.*, creates civil liability for violations of Penal Code § 550, which, in turn, prohibits any person from knowingly presenting false, fraudulent or misleading claims, or writings in support of such claims, to an insurance company. Either the State or any "interested person" on behalf of the State, i.e., a relator like Rockville in a qui tam action, may bring a claim under the IFPA. Insurance Code section 1871.7 provides in relevant part as follows:

> (b) Every person who violates any provision of this section or Section 549, 550, or 551 of the Penal Code shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000), plus an assessment of not more than three times the amount of each claim for compensation, as defined in Section 3207 of the Labor Code or pursuant to a contract of insurance. The court shall have the power to grant other equitable relief, including temporary injunctive relief, as is necessary to prevent the transfer, concealment, or dissipation of illegal proceeds, or to protect the public. The penalty prescribed in this paragraph shall be assessed for each fraudulent claim presented to an insurance company by a defendant and not for each violation.

Penal Code section 550 provides in relevant part as follows:

> 550. (a) It is unlawful to do any of the following, or to aid, abet, solicit, or conspire with any person to do any of the following:
> ...
> (6) Knowingly make or cause to be made any false or fraudulent claim for payment of a health care benefit.
> (7) Knowingly submit a claim for a health care benefit that was not used by, or on behalf of, the claimant.

> (8) Knowingly present multiple claims for payment of the same health care benefit with an intent to defraud.
>
> (b) It is unlawful to do, or to knowingly assist or conspire with any person to do, any of the following:
> (1) Present or cause to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or **misleading** information concerning any material fact.
> (2) Prepare or make any written or oral statement that is intended to be presented to any insurer or any insurance claimant in connection with, or in support of or opposition to, any claim or payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or **misleading** information concerning any material fact.
> ...

Cal. Penal Code § 550(a)(6), (7) and (8), (b)(1) and (2).

IV. DISCUSSION AND ANALYSIS

a. Standard for Summary Judgment

Under California Code of Civil Procedure, § 437c, an action or a cause of action within it is subject to disposition by summary judgment if there is no triable issue of material fact with respect to any element of the action or claim. The moving party bears the initial burden of producing evidence sufficient to make a prima facie showing of the absence of a triable issue of fact; once it makes that showing, the burden shifts to the opposing party to present evidence sufficient to support a prima facie showing of the existence of a triable issue of material fact. *Aguilar v. Atlantic Richfield Co.*, 25 Cal.4th 826, 850 (2001).

To prevail here, Sutter "must present evidence that would require a reasonable trier of fact not to find" that Sutter had knowledge that its billing for anesthesia was false, fraudulent or misleading. *Id.* at 851. Sutter "must present evidence and may not simply point out through argument that the plaintiff lacks needed evidence." *Boyle v. CertainTeed Corp.* 137 Cal.App.4th 645, 652, (2006). If Sutter succeeds, the burden then shifts to plaintiffs.

"There is a triable issue of material fact if, and only if, the evidence would allow a reasonable trier of fact to find the underlying fact in favor of the party opposing the motion in accordance with the applicable standard of proof." *Id.* The motion must be supported by

admissible evidence. *24 Hour Fitness, Inc. v. Sup. Ct.*, 66 Cal.App.4th 1199, 1211(1998). When the uncontradicted facts are susceptible of only one legitimate inference, summary judgment is appropriate. *Jolly v. Eli Lilly & Co.*, 44 Cal.3d 1103, 1112 (1988). Plaintiffs may defeat summary judgment if the evidence raises an inference that suggests that Sutter knew that its anesthesia billing was false, fraudulent or misleading. But that inference must be reasonable and logical and cannot be based on speculation or surmise. *See* Weil & Brown, *Cal. Practice Guide: Civil Procedure Before Trial* (The Rutter Group 2012), para. 10:260, at 10-112; *see also* Evid. Code sec. 600(b)("An inference is a deduction of fact that may logically and reasonably be drawn from another fact or group of facts found or otherwise established in the action."); *Annod Corp. v. Hamilton & Samuels* (2002) 100 Cal.App.4th 1286, 1298-1299 (inferences may not be derived from "speculation, conjecture, imagination or guesswork").

b. <u>What Plaintiffs Must Prove to Establish Liability under the IFPA based on Penal Code Section 550</u>

The IFPA expressly incorporates Penal Code Section 550 ("Section 550"), creating civil liability for "[e]very person who violates any provision of this section or Section 549, 550, or 551 of the Penal Code ..." As stated above, section 550 makes it unlawful to "knowingly" make a false or fraudulent claim for payment of a health care benefit, "knowingly" submit a claim for a health care benefit that was not used by the insured, or "knowingly" assist or conspire with any person in the presentation of false or misleading information in support of a payment for an insurance benefit. The IFPA imposes civil liability only if there is a violation of Section 550. The IFPA does not change the elements of section 550, but incorporates it entirely. Thus to prove their IFPA claims here, Plaintiffs must prove the elements of a section 550 claim.[1]

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[1] Plaintiffs cite to *People ex rel. Allstate Ins. Co. v. Muhyeldin* (2003) 112 Cal.App.4th 604, 610 in support of their argument that the elements of fraud under the IFPA based on Penal Code section 550 are somehow different. In *Muhyeldin,* the court distinguished between the burden of proof in civil cases (usually preponderance of the evidence) and that in criminal cases (beyond a reasonable doubt). While undoubtedly there is a different burden of proof in criminal and civil cases, that difference does not change the elements that must be proved under the IFPA, which, again, expressly incorporates Penal Code Section 550.

Sutter argues that to prove an IFPA violation based on section 550, plaintiffs must prove that defendants had a specific intent to defraud. Sutter's Motion at 8. But the California Criminal Jury Instructions, "CALCRIM" do not use the terms "specific intent" and "general intent". As stated in the Guide for Using Judicial Council of California Criminal Jury Instructions,

> The present addition of CALCRIM Jury Instructions do not use the terms general and specific intent because while these terms are very familiar to judges and lawyers, they are novel and often confusing to many jurors. Instead, if the defendant must specifically intend to commit an act, the particular intent required is imposed without using the term of art, "specific intent."

Under CALCRIM 2000, applicable to Insurance Fraud: Fraudulent Claims (Pen. Code sec. 550 (a)(1), (4)-(7) & (9)), defendants are guilty of insurance fraud if they (1) present or cause to be presented a false of fraudulent claim for payment for a loss or injury; or prepared, made or signed or subscribed a document with the intent to present or use it or allow it to be presented to support a false of fraudulent claim; (2) the defendant knew that the claim was false of fraudulent; and (3) when the defendant did that act, he/she intended to defraud. CALCRIM 2000. The instruction goes on to state that "Someone intends to defraud if he or she intends to deceive another person either to cause a loss of (money[,]/ [or] goods[,]/ [or] services[,]/ [or] something [else] of value), or to cause damage to, a legal, financial, or property right." *Id.*

Thus, to prove a violation of section 550, and a corresponding violation of the IFPA, plaintiffs here are required to prove three elements: (1) presentation of a false or fraudulent claim; (2) knowledge of falsity or fraudulent claim; and (3) intent to defraud.

There is no dispute that the Sutter Defendants presented claims to insurers for payment. The court has already found that there is a triable issue of fact regarding whether the claims for payment here were false or fraudulent. 1/31/13 Order on Falsity MSJ at 9; 4/18/13 Order Affirming Falsity Order at 4. At issue in this motion, is whether Sutter had knowledge of the falsity or fraudulent nature of the claims submitted for payment. If a jury finds that Sutter had knowledge of the falsity or fraudulent nature of the submitted or presented claims, then an intent to defraud will be inferred. As stated by the court in *People v. Scofield,* 17 Cal.App.3d 1018,

1026 (1971), a person or entity "who willfully submits a claim, knowing it to be false, necessarily does so with intent to defraud." *See also People v. Booth,* 48 Cal.App.4th 1247, 1254 (1996) (presenting claims with knowledge of their false or fraudulent or misleading nature necessarily evinces an intent to defraud).

The court thus evaluates whether there is a triable issue of fact regarding whether Sutter had knowledge that the claims it was submitting for payment were false of fraudulent.

c. Whether it can be established as a matter of law that Sutter did not have Knowledge of the False or Fraudulent Nature of the Claims Submitted

To prove their case, plaintiffs will have to show that Sutter submitted claims for payment, knowing they were false, fraudulent or misleading, and thereby intended to defraud payers. *Scofield, supra,* 17 Cal.App.3d at 1026; *Booth, supra,* 48 Cal.App.4th at 1254. To prevail on its summary judgment motion, Sutter must show that there can be no reasonable inference drawn from the facts that would show that Sutter knew that it was submitting false, fraudulent or misleading claims for payment.

In its Motion, Sutter outlines the history of the development of the "chargemaster standardization project" in late 2000. In so doing, Sutter notes that in this process, Sutter recognized that it was critically important that Sutter's standardized charges be compliant with all laws and regulations. Declaration of Brian Hunter ("Hunter Dec."), para. 4, Exs. B, C. Sutter emphasizes that the Standardization Project consisted of high-level Sutter personnel with specific knowledge and background in hospital charging and billing processes and included the management services of Arthur Anderson and 3M Corporation. Sutter Reply at 2. Sutter also states that a "guiding principle" of the project was that the changes to standardize the charge structures would be "revenue neutral", accomplished without increasing or decreasing the hospital revenues. *Id.* Sutter states that during the standardization project, Sutter put together the "Surgery Thought Leadership" team to develop the standardized charge structure for operating room services and anesthesia services. *Id.* It was through the standardization project that Sutter developed the chronometric charges for anesthesia challenged in this lawsuit.

Sutter focuses on its state of mind and primarily relies on the declaration of Mr. Hunter and the standardization project.[2] In his declaration, Mr. Hunter repeatedly states that he "believed and continues to believe" that Sutter did not submit false, fraudulent or misleading claims to payers, and that no one ever suggested or stated that there was any intent to defraud payers in developing standardized billing for anesthesia or any other service. *See* Hunter Dec., paras.7, 8-12, 15-17. In its brief in support of its Motion, Sutter states over and over again that during this project, Sutter personnel "believed" and they still "believe" that the use of time based charges for hospital anesthesia services provide an appropriate measure for billing for those services. *See, e.g.,* Sutter's Motion at 12:21, 12:24, 13:25-26; and 13:28-14:2; *see also* Statement of Undisputed Facts, paras. 7, 8, 9, 10, 11 (found in Sutter's brief at 2-6). Sutter argues that for plaintiffs to prevail, they must show that through the standardization project, Sutter intended to create a system-wide policy to make false, fraudulent or misleading 37x anesthesia charges.

Through this evidence, Sutter has presented prima facie evidence that would require a reasonable trier of fact not to find that Sutter had knowledge that its billing for anesthesia was false, fraudulent or misleading. *Aguilar v. Atlantic Richfield Co., supra,* 25 Cal.4th at 851. The burden thus shifts to plaintiffs to present evidence from which a jury could infer that Sutter did have knowledge that its anesthesia billing was false, fraudulent or misleading. *See id.*

The following evidentiary items identified by plaintiffs support reasonable inferences that Sutter knew that it was submitting false, fraudulent or misleading claims for payment such that summary judgment is not properly granted.

First, Plaintiffs present evidence from deposition testimony wherein Sutter employees

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[2] In addition to Mr. Hunter's declaration, Sutter submits the declarations of Melissa Brendt and Michael Laidlaw ("Brendt Dec." and "Laidlaw Dec.", respectively) in support of its Motion. Ms. Brendt attests that none of Sutter's contracts with payers restrict or specify how Sutter may bill for anesthesia services. Brendt Dec., para. 4. She also states that none of Sutter's contracts with its payers incorporates the Blue Cross Blue Shield of Kansas Hospital Billing Manual cited by Plaintiffs in prior motions. *Id.*, para. 6. Ms. Brendt then describes a dispute between Sutter and a health plan, and cites to an attached email exchange that Ms. Brendt claims shows that in this prior dispute the payer did not take issue with how Sutter billed for anesthesia services. *Id.*, para. 7. Plaintiffs object to portions of Ms. Brendt's declaration; these objections are discussed *infra.* Sutter represents that it submitted the declaration of Mr. Laidlaw to explain and refute his deposition testimony repeatedly cited by plaintiffs for the proposition that anesthesia equipment is properly charged under as an OR charge under 36x. Sutter's Reply at 23.

confirmed that between 3 and 4 anesthesia technicians are responsible for covering between 9 and 15 anesthetizing locations. *See* Exhibit 18 to Declaration of Nimish R. Desai in Support of Plaintiffs' Opposition to Sutter's Motion 18, ("Pltfs' Ex."), Benjamin Gao Dep., at 30:23-31:25, 46:15-17:1; Pltfs' Ex. 19, Jatala Dep., at 61;11-62:21, 63:16-22, 74:5-11; 75:2-15. Mr. Jatala testified that the anesthesia technicians do not keep track of how much time they spend in any given room and confirmed that they do not stay in one room the entire time a patient is anesthetized. Consistent with Mr. Gao and Mr. Jatala, Mr. Hunter states in his declaration that he understands that anesthesia technicians do not stay in the room the entire time a patient is anesthetized. Hunter Dec., para. 7. A jury could draw a reasonable inference from this evidence that Sutter knew that using chronometric billing for anesthesia technicians when those technicians did not stay in the room the entire time for which they were billed was false, fraudulent or misleading.

Plaintiffs next cite two different parallel situations when Sutter does not charge for anesthesia services because there is no Sutter personnel monitoring or providing those services. *See* Pltfs' Opp. at 12-14, 16-19. First, Plaintiffs cite to Sutter's billing practices for conscious sedation ("CS"). Plaintiffs cite to several different statements by Cathy Meeter, Sutter's Charge Description Master Director, suggesting that Sutter only charges for CS when Sutter personnel are in attendance. In an email, Ms. Meeter stated that CS charges apply only "if there is a dedicated hospital staff person that does nothing else but assist the physician in monitoring the patient while sedated ..." Pltfs' Ex. 23, at SH 210337. She also stated that "The [37x] charge is for the persons, not the monitoring equipment or overhead cost. Those [i.e., the monitoring equipment and overhead] ought to be part of the procedure charge itself..." Pltfs' Ex. 8, at SH 1210737. In another email, Ms. Meeter stated that "Hospital billing represents the technical component - labor expenditure by the hospital ... this code represents that labor expenditure by the hospital ... if you supply an additional nurse to be the independent, trained observer ... you should generate a separate charge ..." Pltfs' Ex. 24, at SH 663432. This evidence shows that Sutter only charges for CS if there is a Sutter professional present, and infers Sutter's knowledge that anesthesia charges under the 37x code are for persons, not equipment.

Plaintiffs next cite to the way Sutter charges for anesthesia during Labor and Delivery ("L&D"). L&D patients sometimes get anesthesia in the form of an epidural. As with the Operating Room ("OR") timed charges incurred by patients in the OR, L&D patients incur timed charges while in L&D. But in the OR, patients also incur timed charges for anesthesia. There is no such timed anesthesia charge for L&D patients. Sutter does not impose a 37x charge beyond the L&D hourly charges, even though the anesthesia equipment might be in use, unless a Sutter-employed certified registered nurse anesthetist ("CRNA") provides the epidural. Pltfs' Ex. 5, Meeter Dep. at 243:7-245:25; 237:5-22. As stated by Ms. Meeter, an additional charge cannot be applied because "there is no real expense carrie[d] by the hospital ... to start and monitor the epidural." Pltfs' Ex. 27, SH 485099. Also as stated in an email from Kathy Johnson, Sutter's Director of Billing Compliance & Revenue Quality to Ms. Meeter, when Sutter facilities did apply a timed anesthesia charge to L&D patients even though there was no additional Sutter staff, "[w]e, in essence, were double charging for the same service." Pltfs' Ex. 26, at SH 1210351.

Plaintiffs argue that based on the foregoing evidence, "Sutter knows that if it is billing a patient on a time basis for an anesthesia service, and that the charge is being applied above and beyond a times charge for the OR in which the anesthesia takes place, that it should be providing some additional service beyond providing that OR. Yet, as to the claims at issue in this lawsuit, there is simply no one at Sutter who provides that 'service' – there is only the anesthesiologist who separately bills for his or her time." Pltfs' Opp. at 17. A jury could infer from the evidence identified by plaintiffs related to CS and L&D, that Sutter knew when it was separately billing for anesthesia in the OR, it was double billing and thereby submitting a false, fraudulent or misleading bill. This evidence is sufficient to create a triable issue of fact regarding Sutter's knowledge of the false, fraudulent or misleading nature of its bills.

Plaintiffs also cite to a complaint by "Patient B" arguing that the way Sutter handled this complaint shows knowledge of its false, fraudulent or misleading billing. When Ms. B got her bill that included anesthesia services, she challenged the charge for anesthesia. Pltfs' Ex. 28 at SH 897106, 897111 (May 27, 2011 letter from Ms. B.). Sutter first responded that the charge

was for "hospital operational cost[s]." Pltfs' Ex. 32 at 881900. Ms. B. responded as follows: "I need something in writing that supports the charge and the services rendered. It is not okay to be charged almost $5000 on top of the nursery charge ($4500) for what? The charges should be reflective of services rendered." Pltfs' Ex. 32 at 881899. Sutter responded that the anesthesia charge was for the NICU nurse in attendance during the MRI procedure, for an anesthesia nurse throughout the procedure, for use of IV equipment and gas and any applicable monitoring equipment, as well as recovery room charges. Pltfs' Ex. 32 at 881898. When Ms. B again challenged the charge stating that these services were all charged elsewhere and no additional service was provided (Pltfs' Ex. 32 at 881897), Sutter's stated its charge was valid, and again justified the charge by stating that the anesthesia nurse was available for the duration of the service. Pltfs' Ex. 32 at 881896. Rather than provide documentation, however, Sutter decided to drop the charge. *Id.*

The manner in which the Ms. B. complaint was handled, and the evidence showing that Sutter felt the need to justify the anesthesia charge by falsely arguing that a nurse was present, suggests that Sutter knew that by billing for anesthesia services, when no additional personnel were consistently present, is improper. Based on this evidence, a jury could infer that Sutter knew that it had to have additional personnel to justify an anesthesia charge, and when it billed for anesthesia without the additional personnel, it was submitting a false, fraudulent or misleading bill. This evidence is sufficient to create a triable issue of fact regarding Sutter's knowledge of the false, fraudulent or misleading nature of its bills.

Sutter represents that the anesthesia charge under 37x is not only for personnel, but also for "equipment and supplies that the anesthesiologist uses to deliver anesthesia and monitor the patient." Hunter Dec., para. 6. Evidence highlighted by Plaintiffs creates a factual dispute as to whether anesthesia equipment is properly billed under the code 37x.

Plaintiffs point to Sutter's policy that "routine supplies" are "non-billable." Pltfs' Ex. 9, at SH 208523 and SH 208537. "Routine Supplies" include the "cost of gowns, drapes, reusable instruments and capital equipment (whether owned or rented) used in the surgery of OR." *Id.* at SH 208538. Sutter's policy states that "Routine supplies should not be billed to any payer or

patient. The costs for the routine supplies should be factored into the setting or procedure charge." *Id.*

Sutter's "Policy for Establishment of Charge Codes for Supplies", provides guidelines for determining which supplies are routine, and therefore non-billable. Pltfs' Ex. 10 at SH 499506 – 499507. This Policy states that "Routine supplies are usually used during the customary course of treatment, are included in the unit supplies and are not designated for a specific patient." *Id.* at SH 499507. "Routine supply items ... would generally be available to all patients receiving supplies in that location i.e. emergency room, operating room, cast room, routine nursing area, etc." *Id.*

Ms. Meeter has testified that anesthesia is a routine part of surgical procedures performed in the OR: "If you're in the OR, you're going to have anesthesia. You don't go to the OR without a need for anesthesia." Pltfs' Ex. 5, Meeter Dep. at 180:4-9; 182:6-12. Given that anesthesia is a regular part of the OR, a jury could infer that routine supplies includes anesthesia equipment. In fact, a Sutter spreadsheet identified by plaintiffs includes "anesthesia units" and "anesthesia unit vaporizers" in its list of OR equipment. Pltfs' Ex. 20 at 66095, pp. 21-22. This further suggests that a jury could conclude that anesthesia equipment is properly billed as OR equipment under billing code 36x.

The evidence identified by Plaintiff does not conclusively establish that Sutter knew that it was submitting false, fraudulent or misleading bills to payers, but could suggest to a jury that Sutter understood that anesthesia equipment costs were captured in the OR charge. Plaintiffs have raised triable issues of fact as to whether Sutter had knowledge that its billing for anesthesia equipment under revenue code section 37x was false, fraudulent or misleading.

And finally, the billing of "gases" by some Sutter facilities under both the 25x and 37x billing codes suggests that Sutter had knowledge of its double billing. Sutter's anesthesia protocol lists "gases" as what is "included in charge" for the general anesthesia charge, under the 37x anesthesia charge code. Pltfs' Ex. 12. The evidence shows, and Sutter does not dispute, that some Sutter hospitals charged for anesthesia gases under the 25x pharmacy code. Pltfs' Ex. 5, Meeter Dep. at 327: 23-328:8; 333: 14-18. When Sutter finally acted to cease this admittedly

erroneous billing, there was no corresponding follow-up with payers of patients to correct any double bills that had already gone out. Sutter does not deny that there were mistakes made by some Sutter hospitals following the standardization project with regard to billing for gases. Sutter explains that these were mistakes that certain Sutter hospitals made when they continued to charge for anesthesia gases under 25x ("Pharmacy") after the standardization project, instead of Revenue Code 37x, Anesthesia Services. Sutter maintains that this mistake was rectified as soon as it was revealed and argues that plaintiffs have not actually presented evidence that gas billed under 25x after the standardization project was also billed under the 37x code

The evidence identified by plaintiffs suggests that there was double billing and that although Sutter ceased the alleged double billing when it was discovered, it did not try to correct those bills. A jury could infer from this lack of follow up on the part of Sutter (which follow up could have resulted in substantial reimbursement of fees paid) that Sutter was aware that it was double billing.

Sutter argues that plaintiffs take snippets or isolated statements from deposition testimony and emails from the last 12 years to try to suggest knowledge of wrongdoing on Sutter's part. Citing *Annod*, *supra*, 100 Cal.App.4th at 1299, Sutter argues that the evidence presented is not of sufficient magnitude to raise a triable issue of fact in light of the evidence as a whole, showing no knowledge of wrongdoing that suggests an intent to defraud, much less that Sutter implemented through the standardization project a system-wide policy to make false, fraudulent or misleading 37x anesthesia charges.

In its lengthy oral argument in support of its motion, Sutter attempted to explain away the various documents and portions of deposition testimony presented by Plaintiffs to establish Sutter's knowledge of the falsity of its billing. However, the fact that these matters require an attempt to explain them away shows in itself the existence of triable issues of fact. Sutter's evidence measured against plaintiffs' evidence creates issues of fact for the jury.

The issues of knowledge and intent are typically and singularly questions of fact resolved by the jury. *See Smith v. Selma Cmty. Hosp.*, 188 Cal.App.4th 1, 36 (2010) ("inquiry into a party's state of mind and motives is a subjective one that poses a question of fact"). In most

cases there is often no direct evidence of state of mind. Instead, Plaintiffs are permitted to show actual knowledge of false, fraudulent or misleading claims, which in turn shows intent to defraud under Section 550, through circumstantial evidence and inference. As discussed above, Plaintiffs have presented sufficient evidence from which a jury could draw reasonable inferences that Sutter had knowledge that its bills were false, fraudulent or misleading. Thus, whether Sutter had the requisite knowledge to be liable under the IFPA is a question for the jury.

d. Evidentiary Objections

Plaintiffs filed two objections to Ms. Brendt's declaration. The first objection is to page 3, lines 18-20; this objection is OVERRULED. Sutter has adequately authenticated the attached email. The second objection is to page 3, lines 22-24; this objection is also OVERRULED. Sutter has established that the persons writing the email have the expertise to opine on whether the anesthesia was properly billed.

Sutter filed objections to certain evidence presented in Plaintiffs' opposition to Sutter's Motion, including the declaration of Henry Miller, PhD. Those objections are OVERRULED. The evidence presented is summaries of data produced by Sutter. (See also 1/31/13 Order on Falsity MSJ.)

V. ORDER

Based on the foregoing, Sutter's Motion for Summary Judgment is DENIED.

Dated: July 18, 2013

Hon. William L. Bettinelli (Ret.)
Referee

IT IS SO ORDERED.

Dated: Sept. 13, 2013

Judge of the Superior Court
JUDY H. HERSHER

SUPERIOR COURT OF CALIFORNIA
COUNTY OF SACRAMENTO

PROOF OF SERVICE BY EMAIL & U.S. MAIL

Re: Rockville Recovery Associates Ltd vs. Multiplan, Inc., et al.
Reference No. 1100065416

I, DAVID CASTILLO, not a party to the within action, hereby declare that on July 18, 2013 I served the attached ORDER ON MOTION OF SUTTER DEFENDANTS FOR SUMMARY JUDGMENT ON SPECIFIC INTENT ELEMENT OF PLAINTIFFS' CLAIM on the parties in the within action by Email and by depositing true copies thereof enclosed in sealed envelopes with postage thereon fully prepaid, in the United States Mail, at San Francisco, CALIFORNIA, addressed as follows:

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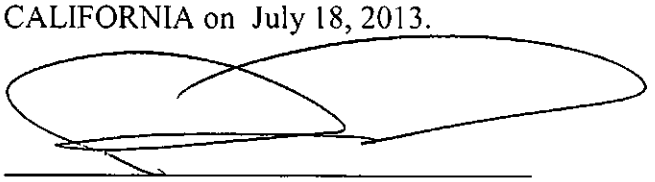
Sutter Health

I declare under penalty of perjury the foregoing to be true and correct. Executed at San Francisco, CALIFORNIA on July 18, 2013.



DAVID CASTILLO
dcastillo@jamsadr.com

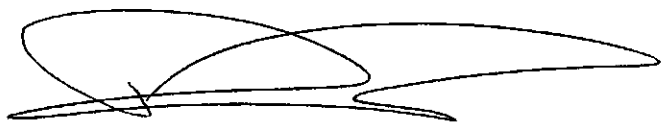
PROOF OF SERVICE BY U.S. MAIL

Re: Rockville Recovery Associates Ltd vs. Multiplan, Inc., et al.
Reference No. 1100065416

I, DAVID CASTILLO, not a party to the within action, hereby declare that on July 18, 2013 I served the attached ORDER ON MOTION OF SUTTER DEFENDANTS FOR SUMMARY JUDGMENT ON SPECIFIC INTENT ELEMENT OF PLAINTIFFS' CLAIM; PROOF OF SERVICE on the parties in the within action by depositing true copies thereof enclosed in sealed envelopes with postage thereon fully prepaid, in the United States Mail, San Francisco, CALIFORNIA, addressed as follows:

Superior Court of Sacramento
Main Courthouse
720-9th Street
Sacramento, CA 95814-1398

I declare under penalty of perjury the foregoing to be true and correct. Executed at San Francisco, CALIFORNIA, on July 18, 2013.



DAVID CASTILLO