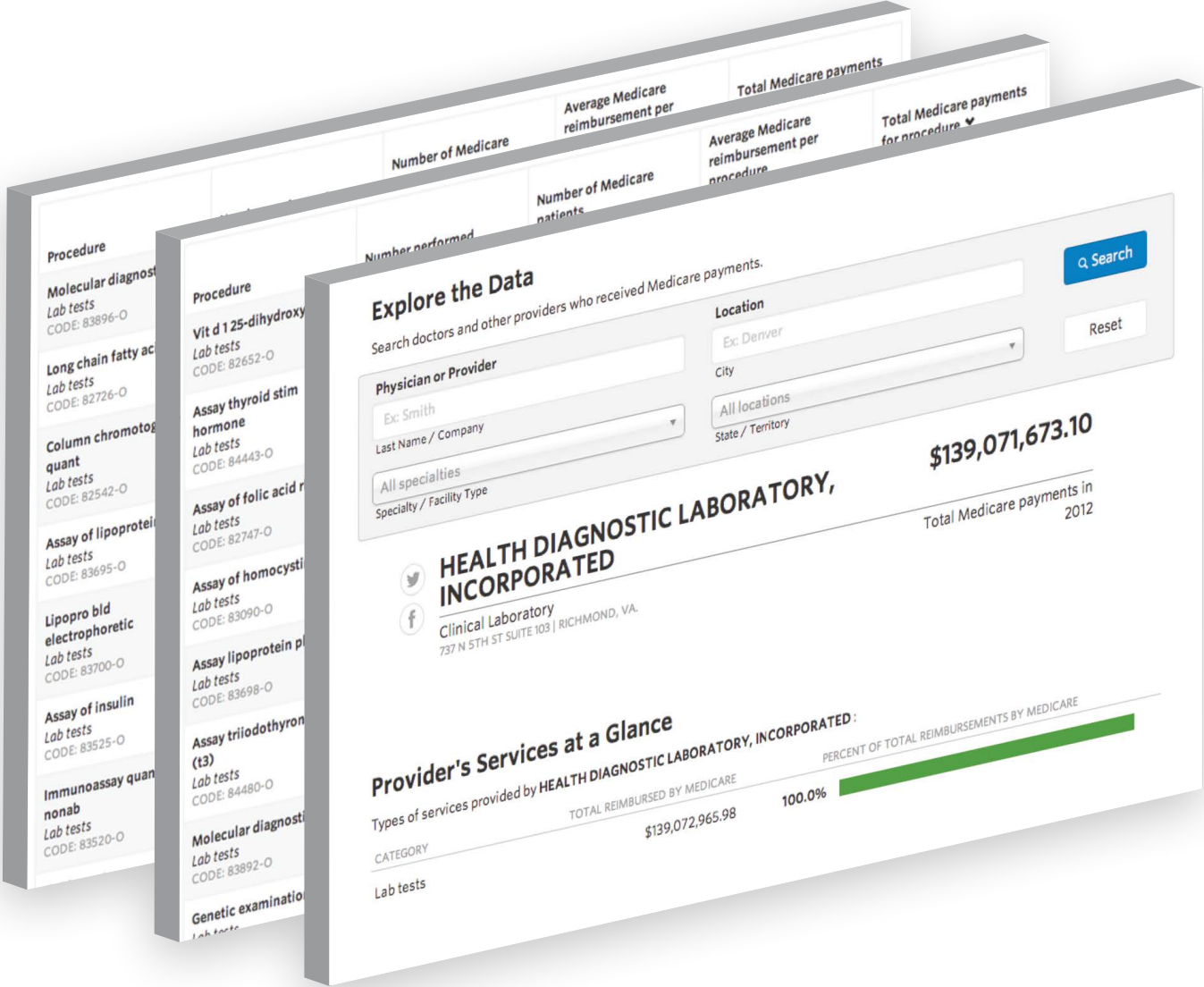


THE WALL STREET JOURNAL.



MEDICARE UNMASKED

The Wall Street Journal forced the government to publicly release important Medicare data that had been kept secret for decades.



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MEDICARE UNMASKED

Taxpayers Face Big Tab For Unusual Doctor Billings

BY JOHN CARREYROU, CHRISTOPHER S. STEWART AND ROB BARRY
TUESDAY, JUNE 10, 2014

Ronald S. Weaver isn't a cardiologist. Yet 98% of the \$2.3 million that the Los Angeles doctor's practice received from Medicare in 2012 was for a cardiac procedure, according to recently released government data.

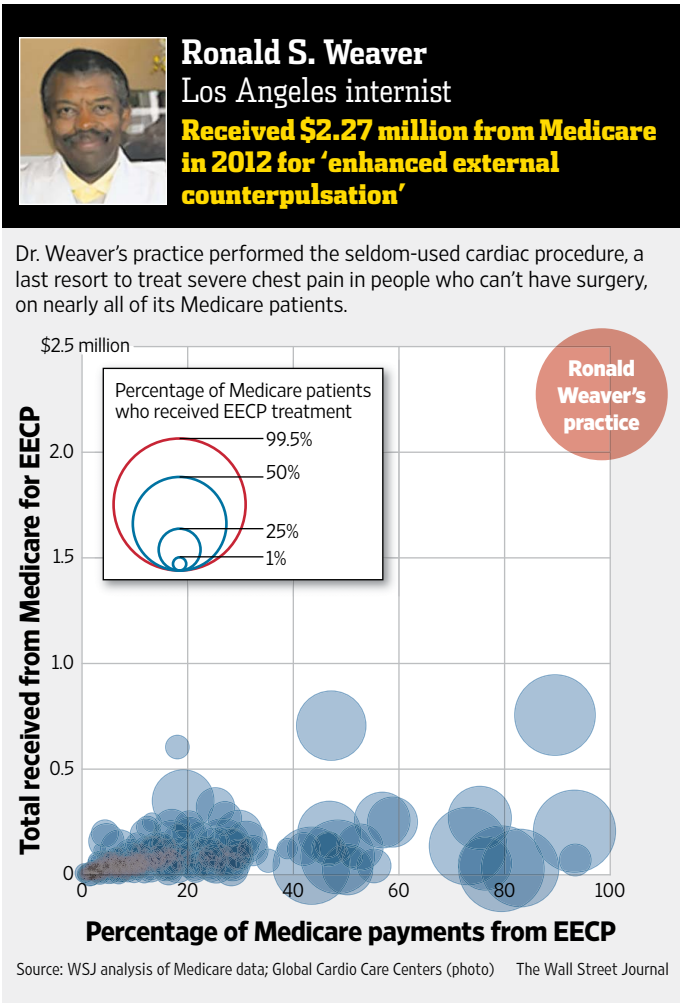
The procedure is rarely used by the nation's heart doctors. Patients are strapped to a bed with three large cuffs that inflate and deflate rhythmically to increase blood flow

through the arteries — a last resort to treat severe chest pain in people who can't have surgery.

The government data show that out of the thousands of cardiology providers who treated Medicare patients in 2012, just 239 billed for the procedure, and they used it on fewer than 5% of their patients on average. The 141 cardiologists at the Cleveland Clinic, renowned for heart care, performed it on just six patients last year. Dr. Weaver's clinic administered it to 99.5% of his Medicare patients — 615 in all — billing the federal health-insurance program for the elderly

and disabled 16,619 times, according to the data.

In an interview, Dr. Weaver said he learned about the procedure by "reading lots of articles, studies and clinical trials" and decided to build his practice around it. There is no consensus in the cardiology community whether the treatment provides significant benefits. Dr. Weaver, who



likens it to “exercise while lying on your back,” says it improves his patients’ health.

More than 2,300 providers earned \$500,000 or more from Medicare in 2012 from a single procedure or service, according to a Wall Street Journal analysis of Medicare physician-payment data made public for the first time in April. A few of those providers, including Dr. Weaver, collected more from the single procedures than anyone else who billed for them — by very large margins. The data release was prompted by a Journal legal effort to make the information public.

There is nothing inherently wrong with medical professionals billing primarily for one thing. Some doctors specialize in certain procedures and fashion their practices around them. At times, the billings of one doctor can encompass the work of a staff, including other doctors, physician assistants and nurses, distorting comparisons with other doctors in that field.

A closer look at a few of the doctors who make most of their money from just a few procedures reveals that they are operating outside their areas

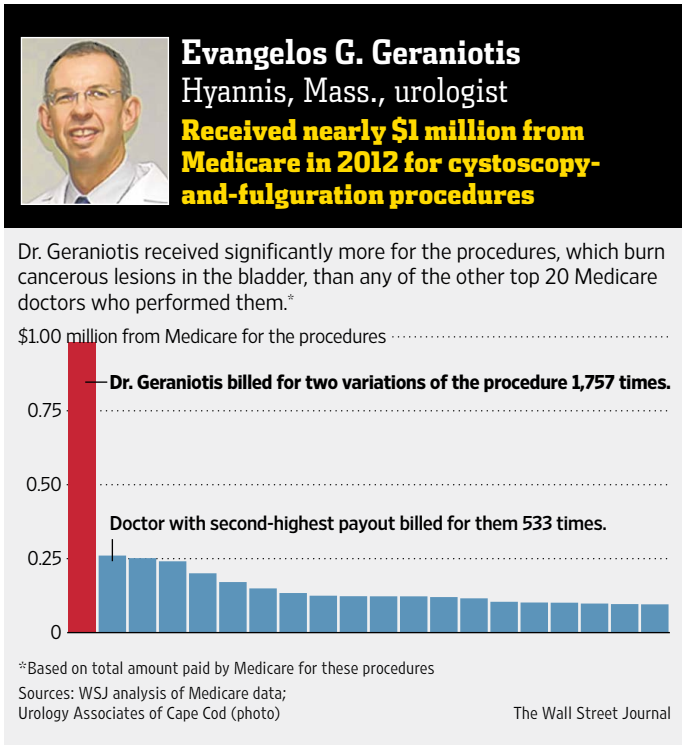
of expertise or deviating from standard medical practice.

The doctors featured in this article say financial incentives play no role in their treatment patterns, and some argue that the procedures save the government money by keeping patients out of hospitals.

Among the doctors whose billings stand out is Evangelos G. Geraniotis, a urologist in Hyannis, Mass. Dr. Geraniotis received \$2.1 million from Medicare in 2012, the most of any member of his specialty.

Nearly \$1 million of that sum came from a procedure not considered routine in a urological practice. Known as a “cystoscopy and fulguration,” it involves threading a scope up the male urethra to burn potentially cancerous lesions inside the bladder.

According to his Medicare billings, Dr. Geraniotis performed two variations of the procedure 1,757 times in 2012.



Of the 8,791 providers whose specialty is listed in the Medicare data as urology, 973 billed for the procedure, doing so an average of 38 times. The urologist who billed for the second-most performed the procedure less than one-third as often as Dr. Geraniotis did, the data show.

Dr. Geraniotis said Cape Cod retirees account for the majority of his practice. He said many have bladder issues such as urinary bleeding, but otherwise he isn’t sure why he stands out in his use of the procedure.

“If I see something, I say: ‘Let’s cauterize it and take care of it,’ whereas someone else might wait and see,” he said. “I guess you could call it a more aggressive approach.”

Dr. Geraniotis said the more than \$500 he received from Medicare each time he billed for the procedure played no role in his medical judgment and, by performing the procedure in his office, he keeps patients out of the hospital.

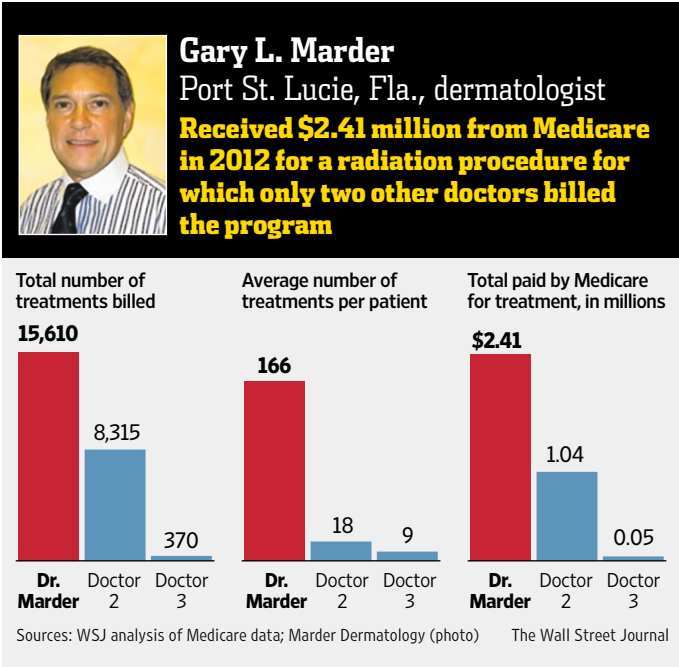
“My style of practice is an outlier, but I don’t think it reflects anything more than my trying to do good for my patients. I think I’m an honest guy,” he said.

In Port St. Lucie, Fla., Gary L. Marder, a dermatologist, specializes in treating melanoma with radiation. Dr. Marder’s website, which features photos of smiling elderly couples, says he has cured more than 100,000 skin cancers.

Medicare paid Dr. Marder \$3.7 million in 2012 — \$2.41 million of which came from a radiation treatment billed by just two other doctors in the data, which doesn’t include hospital billings. Neither of them came close to billing as much for it as Dr. Marder.

David Beyer, a radiation oncologist in Scottsdale, Ariz., said the procedure code Dr. Marder used to bill Medicare corresponds to higher-voltage machines than the one pictured on Dr. Marder’s website. Such higher-voltage machines require substantial shielding and a contained room typically found in the radiation-oncology departments of hospitals, Dr. Beyer said.

Under Medicare guidelines, the lower-voltage machine



pictured on Dr. Marder's website was reimbursed at a rate of about \$22 per treatment in 2012, radiation oncologists say. Dr. Marder received an average of \$154 per treatment by billing under the code for the higher-voltage machine.

In an email exchange, Dr. Marder said he used a machine different than the lower-voltage one pictured on his website, but didn't respond to a question about what kind. Dr. Marder said he had "professionals who can vouch for my correct coding," although he didn't provide their names.

Dr. Marder billed for the procedure, using the more lucrative code, 15,610 times in 2012, and performed the procedure on 94 patients, according to the Medicare data. That works out to 166 treatments per patient, on average.

Dr. Beyer, the Arizona radiation oncologist, said the maximum number of radiation treatments appropriate per skin-cancer lesion is 35, and a more normal regimen would be 20. When a patient has several lesions, they commonly get treated simultaneously and are billed for as a single treatment, he said.

Dr. Marder said he billed for each lesion separately and treated each lesion about 40 times, explaining his high billing count per patient.

In 1998, Dr. Marder was disciplined by Florida's Board of Osteopathic Medicine for alleged "fraudulent" billing. The board fined him \$2,500 and ordered him to take courses in medical record-keeping and medical risk management. He neither admitted nor denied the allegations.

Dr. Marder said his medical care "was never in question" and that the medical board merely asked him to better document in his medical charts the justifications for his billings, which he said he has done since then.

Some of the Medicare doctors whose billings stand out aren't performing procedures that are particularly technical or specialized.

The practice of James E. Beale, an orthopedic surgeon in the Detroit area, received \$3.7 million from Medicare in 2012, more than any other member of his specialty, according to the data.

Dr. Beale's practice accomplished that despite not performing a single surgery on a Medicare patient. His chief Medicare revenue source was "manual therapy techniques," which the coding manual used by Medicare to set reimbursements describes as a massage or manipulation of various regions of the body, lasting 15 minutes.

Dr. Beale's practice billed Medicare for it 107,670 times and received \$2.3 million. By contrast, the average doctor

or physical therapist in the data who billed for the technique performed it 520 times and was reimbursed less than \$11,000 for it.

How Dr. Beale’s practice came to bill for so many massages is unclear. In a brief interview on the doorstep of his large brick home, he said of the Medicare billing that appears under his name: “What you see, it wasn’t me.” He declined to answer additional questions.

Iris Winchester, who works with Dr. Beale at an orthopedic clinic in a Detroit suburb, said the Medicare payments for the manual therapy went to a company called Abyssinia Love Knot Physical Therapy that she and Dr. Beale worked for until July 2012. Although Ms. Winchester and Dr. Beale opened their own clinic at that time, Ms. Winchester said Abyssinia continued billing Medicare under Dr. Beale’s name, which Abyssinia denied.

“You need to follow the money,” she said, declining to comment further.

Abyssinia is owned by Shirley Douglas, a former home-health aide who founded a network of physical-therapy centers several years ago. Ms. Douglas, who also is a preacher and goes by “Pastor Shirley,” said she ran her facilities in partnership with Dr. Beale until mid-2012.

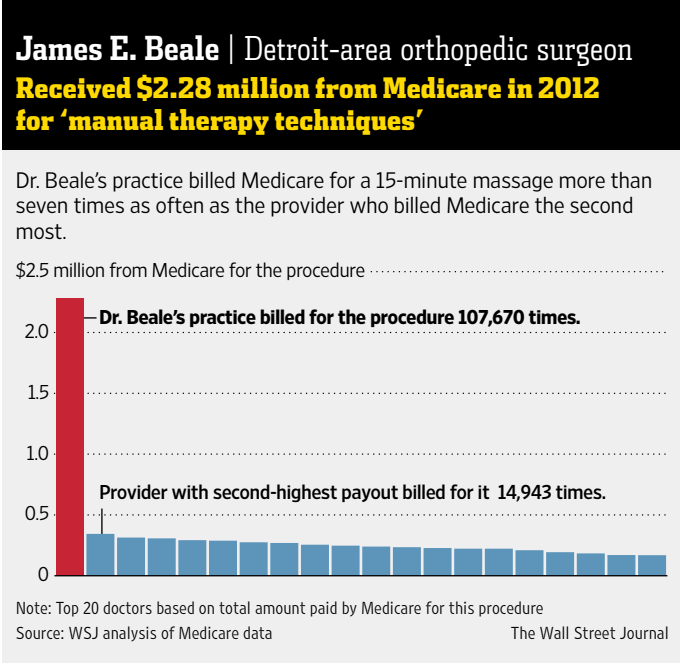
In 2012, “we did a lot of massages,” Ms. Douglas said, adding that the billing under Dr. Beale’s name reflected the work of a staff of doctors and physical therapists, not just one person.

But she said her facilities accounted for just \$1.5 million of Dr. Beale’s \$3.7 million in total Medicare billings in 2012. She said Dr. Beale and Ms. Winchester’s new clinic must have accounted for the remainder of the 2012 billings, something Ms. Winchester denies.

The Medicare payment data show that Dr. Beale’s practice performed the 15-minute massage an average of 149 times per patient for average Medicare billings per patient of \$3,155.

Medicare since has capped the amount it reimburses for physical therapy at \$1,920 per patient a year.

“Medicare said: ‘No more. This is too expensive,’ “ Ms.



Douglas said, adding that her billings for the procedure have declined sharply this year.

Dr. Beale's medical license was temporarily suspended by Michigan's medical board in 1988 for letting a physician assistant use prescription pads bearing his signature to prescribe controlled substances. The medical board separately reprimanded him in 2003 for "negligence" in the treatment of a patient. Dr. Beale couldn't be reached for comment on the sanctions.

Dr. Weaver, the Los Angeles internist whose practice billed Medicare the most for the seldom-used cardiac procedure, acknowledged having no specialized training in cardiology beyond a residency in internal medicine. He is rarely at his clinic, according to former employees. By his own account, he doesn't see patients himself but employs two to three cardiologists for that purpose.

The former employees say the driving force behind Dr. Weaver's clinic is a colleague, Sara Soulati, whose company manages the clinic. Though Ms. Soulati isn't a doctor, she described herself in an interview as an "expert" in the procedure, which is called "enhanced external counterpulsation," or EECP.

Some doctors argue the procedures keep patients out of hospitals.

Medicare covers EECP only for patients who have "disabling" angina, a kind of persistent and extreme chest pain, and who can't have surgery to treat it. Steven Nissen, chairman of cardiovascular medicine at the Cleveland Clinic, characterizes EECP as "a treatment that is, and should be, rarely used" because there are many other more effective ways to address angina.

Ms. Soulati promotes the procedure as a broader preventive measure against cardiovascular disease. In a speech posted on YouTube that she gave at the City of Refuge Church in south Los Angeles, Ms. Soulati said EECP "grows new arteries" and will "save your life." She asked for the names and numbers of congregants interested in the treatment. "God has been great to me because he allowed me to bring the service here," she said. Dr. Nissen says it is improbable that EECP would grow new arteries.

Dr. Weaver says EECP costs about one-fifth as much as surgical procedures such as stenting and results in fewer hospital admissions. Ms. Soulati and Dr. Weaver said they follow "all applicable laws and regulations."

Their clinic resembles a spa. In several dark treatment rooms, patients lay on about two dozen beds, as the EECP machines emitted pumping sounds. Outside, vans adver-

tising a free EECp trial picked up and dropped off patients, most of them elderly.

Internal emails reviewed by the Journal show the staff was instructed to make frequent calls to patients. In September 2012, Ms. Soulati emailed her staff: “We had VERY low numbers today ... please make sure everyone is on the phone all day long.” One day the following month when 135 patients were scheduled for treatment but only 83 showed up, she emailed: “Please work hard and get our numbers back to the 90’s. our goal is to stay above 90.”

A policy document from the clinic notes that “it is so hard to get EECp covered through insurance,” advising employees to reassure patients that “we are the experts at getting Medicare to pay when others wouldn’t be able to.”

Dr. Weaver said Ms. Soulati’s emails were “primarily motivated by a desire to assure that patients receive the greatest available benefit from their treatments ... without interruption.”

The clinic’s patients receive tests at a neighboring laboratory, according to the former employees. Ms. Soulati owns the lab, GCC Imaging. Dr. Weaver said the patients who come for EECp tend to have conditions requiring diagnostic testing, and Ms. Soulati’s lab is “the only such facility in the building.” Ms. Soulati said she agreed with Dr. Weaver’s comments.

The government data show the lab collected nearly \$1 million from Medicare in 2012. It billed the program for medical tests on 626 patients, roughly the same number as were treated with EECp at Dr. Weaver’s clinic.

Matthew Dolan and Tom McGinty contributed to this article.