MANAGED CARE LITIGATION UPDATE®

Newsworthy

BCBS Minnesota reported to be cutting payments for mental health therapy. http://www.startribune.com/blue-cross-payment-cuts-prompt-protest-by-minnesota-mental-health-providers/442808153/

Texas law requires free standing ER's to post the networks in which they participate. https://www.texastribune.org/2017/09/21/freestanding-ers-must-now-clearly-state-what-health-insurance-networks/

Pharmacy seeks order enjoining Prime Therapeutics, Walgreens, and Health Care Service Corp. from terminating its participation in Prime's provider network, including Medicare, Medicaid, and BCBS, in part, on anti-trust grounds. *J&S Community Pharmacy, Inc. v. Walgreen Co., et al.*, USDC ND IL, No. 17-06837 (Doc. 1, 09/21/17).

Court dismisses providers' ERISA derivative claims because assignments were made to third party. *Dual Diagnosis Treatment Center, Inc. v. Blue Cross of CA*, USDC CD CA, No. 15-736, Doc. 1175 (09/25/17). *See also* **MCLU Vol. 32**.

Recently filed actions

Progressive Healthcare Solutions, Inc. v. United Healthcare Services, Inc., U.S.D.C. W.D. LA, Doc. No. 6:17-cv-01176, (filed Sept. 18, 2017). Vendor of medical implants contends that it has not been paid despite Dr. Ilyas Munshi, a board-certified neurosurgeon, receiving written authorization "which confirmed coverage for the implantation of medical hardware by Dr. Munshi procured from plaintiff, Progressive." "Progressive submitted claims to United Healthcare for the costs of such hardware" totaling $389,939.61. Coverage was denied on *inter alia* the following grounds: "[t]his service is not reimbursable for this provider in this place of service" and "surgical implants are reimbursed to the facility and are not separately reimbursable."

Humana Health Plan, Inc. v. Hartford Casualty Insurance Company, U.S.D.C. W.D. WA, Doc. No. 2:17-cv-01407, (filed Sept. 18, 2017). Medicare Advantage Organization seeks recovery of "at least $161,853.14 in conditional payments on Medicare claims submitted on behalf of Enrollee" from Defendant's UIM policy following settlement of Enrollee's personal injury claim by Defendant. "Enrollee did not comply with his repayment obligations, meaning Defendant is responsible for reimbursing Humana, even though it has already paid Enrollee."

Thomas M. and Marcia M. v. Aetna Life Insurance Company, U.S.D.C. D. UT, Doc. No. 2:17-cv-01037-DB, (filed Sept. 19, 2017). Parents seek recovery of over $125,000 in mental health benefits on behalf of son, associated with approximately 10 months of treatment at Waypoint Academy, a licensed residential treatment facility in the State of Utah. Following appeal, Aetna "maintained denial of coverage on the basis that Michael's residential treatment was not medically necessary." A prior EOB "stated that the claim would not be paid because Michael could be safely treated at a less intensive level of care."

Thousand Oaks Surgery Center, LLC, Alexander Hersel, M.D., Inc. v. Blue Cross Blue Shield of Massachusetts, Inc., Anthem Blue Cross Life and Health Insurance Company, U.S.D.C. C.D. CA, Doc. No. 2:17-cv-06942-DSF-AGR, (filed Sept. 20, 2017). Removed action in which "[p]laintiffs seek payment from Defendants of professional fees and facility fees in connection with pain management and other health care services …" provided to five patients. Plaintiffs and alleged assignees are OON providers, who submitted 52 claims for billed charges totaling $1,850,637.00. Claims were denied based on plaintiff's alleged failure to provide an itemization, "BCBSMN already paid its share of the claim, the member was not eligible for coverage at the time the services were rendered, and/or Plaintiffs never submitted a reimbursement claim for the services at issue."

B.Z. v. Inthinc Technology Solutions, Inc. and CIGNA Healthcare, Inc., U.S.D.C. D. UT, Doc. No. 2:17-cv-01052-DB, (filed Sept. 20, 2017). Plaintiff received medical services from IHC Health Services, Inc., which submitted claims on behalf of plaintiff, the majority of which were denied on grounds that the treatment was performed OON. "Plaintiff's treatment was due to an emergent health condition [cerebral bleeding and cerebral thrombus and complications due to traumatic biking accident] that prevented her from seeking treatment at an in-network provider." $128,803.35 is the alleged balance due after payment received in the amount of $60,557.46 (or 32% of billed charges). Multiple lawsuits by IHC Health Services, Inc. against major carriers reported in **prior MCLU issues**.

Apex Toxicology, LLC v. United Healthcare Insurance Company, et al., U.S.D.C. S.D. FL, Doc. No. 0:17-cv-61840-WPD, (filed Sept. 21, 2017). Plaintiff and alleged assignee seeks recovery of benefits against United, as plan administrator, and multiple self-funded plans, associated with "United HealthCare's refusal to provide coverage and denial of benefits for toxicology laboratory services in conjunction with testing of patients who were admitted to substance abuse facilities." Plaintiff alleges that a SIU investigator placed a flag on the provider's account so that all submitted claims were not paid. Denial codes included "non-covered charges" and "[p]rocedure code not correct/valid for the services billed or the date of service billed."

Robert S. Fischer, M.D. v. Cigna Health and Life Insurance Company, U.S.D.C. D. NJ, Doc. No. 2:17-cv-07371-ES-JAD, (filed Sept. 22, 2017). Removed action in which provider and alleged assignee contends it rendered emergency medical services to Defendant's beneficiaries, for which it billed a total amount of $35,975 but received an underpayment of $17,873.52. Among other things, plaintiff alleges that N.J.A.C. 11:4-37.3 requires cost sharing for emergency care shall be the same, regardless of whether provided by in-network or OON provider, and Defendant imposed a cost share on the patient inconsistent with this statute. Similar allegations in cases reported at **MCLU Vol. 78, 81, 82, and 87**.

Advanced Ortho Hand Surgery PA v. Oxford Healthcare, U.S.D.C. D. NJ, Doc. No. 2:17-cv-07380-SDW-LDW, (filed Sept. 22, 2017). Removed action in which provider contends having rendered emergency surgery to certain patients, collectively billed $328,314.06, but has not received payment. Basis of non-payment is not stated in underlying Complaint. Similar action filed against Aetna and reported in **MCLU Vol. 45**, and against Anthem BCBS and reported in **MCLU Vol. 48**.

Renee MacLaughlan Bozarth v. Envision Healthcare Corporation, et al. [Anthem Blue Cross and Blue Shield], U.S.D.C. C.D. CA, Doc. No. 5:17-cv-01935-FMO-SHK, (filed Sept. 22, 2017). Removed putative class action "on behalf of all persons … who were provided emergency medical services at an in-network emergency department [ ] by an out-of-network provider employed/hired by EmCare or an affiliate, and received a surprise bill from the provider for an amount beyond the reasonable fair market value rates." "EmCare's conduct violates California law ... Anthem aids and abets in EmCare's unlawful scheme by neglecting its independent duty ... to pay a reasonable and customary amount to an out-of-network physician for emergency services ..."

IHC Health Services, Inc. dba Intermountain Medical Center v. USF Reddaway, Inc. and Blue Cross Blue Shield of Illinois, U.S.D.C. D. UT, Doc. No. 2:17-cv-01068-PMW, (filed Sept. 22, 2017). Hospital and alleged assignee seeks recovery of $15,922.20 as the balance due after payment received in the amount of $4,994.25 (or 24% of billed charges). "The Defendants and/or their agents denied the majority of the claims by contending that the treatment was performed out of network and exceeded usual, customary, and reasonable charges." Plaintiff responds by alleging, "C.R.'s treatment was due to an emergent health issue [small bowel obstruction and other issues] that prevented him from seeking treatment at an in-network provider or seeking authorization." Multiple lawsuits by this provider against major carriers reported in **prior MCLU issues**.

SEE ALSO (similar claim, different patient):

- *IHC Health Services, Inc. dba Intermountain Medical Center v. Health Care Service Corporation [dba BCBS of Montana]*, U.S.D.C. D. UT, Doc. No. 2:17-cv-01075-BSJ, (filed Sept. 25, 2017).
- *IHC Health Services, Inc. dba Utah Valley Hospital, et al. v. Oldcastle, Inc. and Anthem Blue Cross and Blue Shield*, U.S.D.C. D. UT, Doc. No. 2:17-cv-01083-PMW, (filed Sept. 26, 2017).

Harold L. Anness v. Delta Account-Based Healthcare Plan and United Healthcare Services, Inc., U.S.D.C. S.D. OH, Doc. No. 1:17-cv-00640-MRB-SKB, (filed Sept. 22, 2017). Member seeks recovery of benefits associated with medical care and treatment at Good Samaritan Hospital, Cincinnati, Ohio, "including, but not limited to: NUC MED/DX; Diagnostic Radiopharm and stress test." "Defendants denied Plaintiff's claim without explanation and by indicating that no appeal had been received or would be considered." Basis for denial is not stated in Complaint.

Sarah S. v. Aetna Health Management, LLC, U.S.D.C. S.D. FL, Doc. No. 1:17-cv-23513-DPG, (filed Sept. 25, 2017). Member seeks recovery of benefits associated with residential treatment and later partial hospitalization treatment for an eating disorder at Oliver Pyatt-Center, for approximately a four-month period. Plaintiff alleges that Aetna approved a single case agreement

to receive treatment at this OON provider, at in-network treatment coverage rates, but that "AETNA unreasonably terminated coverage for SARAH S.' treatment at the PHP level of care ..." Further, Aetna "fail[ed] to maintain a sufficient provider network that could enable SARAH S. to receive appropriate mental health treatment ..."

Christina Meltzner v. Anthem Insurance Companies, Inc., et al., U.S.D.C. W.D. OK, Doc. No. 5:17-cv-01023-M, (filed Sept. 25, 2017). Plaintiff seeks recovery of benefits on behalf of dependent who "required medical treatment and hospitalization for an illness specifically covered under the group insurance certificate and group insurance policy." The claim(s) were apparently denied, for reasons not specifically stated in the Complaint.

The Plastic Surgery Center, P.A. v. Thales USA, Inc. and Care First Blue Cross Blue Shield, U.S.D.C. D. NJ, Doc. No. 3:17-cv-07489-BRM-LHG, (filed Sept. 26, 2017). Medical practice specializing in plastic and reconstructive surgery, and alleged assignee, alleges it provided services to a patient, for which it "submitted a standard bill for health care services in the amount of $104,968 to Care First." Payment was initially denied, then payment was issued in the amount of $10,483.62 at an "in-network benefit level." "The Plaintiff is entitled to recover further reimbursement from the Plan for the Medical Services." Another lawsuit reported by this provider and covered in **MCLU Vol. 77**.

Ramon Garcia, M.D. v. UnitedHealthcare Services, Inc., U.S.D.C. S.D. FL, Doc. No. 0:17-cv-61890-KMM, (filed Sept. 27, 2017). Removed action in which physician, but suing as a member of his own health benefit plan, seeks recovery of "approximately $29,020.00 in health care costs associated with his participation in the Partial Hospitalization Program at the University of Florida ..." arising out of "his chronic and repeated use of the prescription drug [Xanax]." Benefits were paid for the first nine days of treatment, but denied thereafter "based upon the 'UBH Level of Care Guidelines for the Substance Use Disorders [PHP] Level of Care.'"

Atlantic Shore Surgical Associates v. Horizon Blue Cross Blue Shield of New Jersey, et al., U.S.D.C. D. NJ, Doc. No. 3:17-cv-07534-FLW-DEA, (filed Sept. 27, 2017). Removed action in which OON providers provided a pre-authorized "Laperoscopic sleeve gastrectomy" to a patient, for which the primary surgeon billed $27,265.60 and the assistant surgeon billed $10,906.24. "Defendant, BCBS paid a total of $2,840.00 toward these reasonable charges ... [and] represents a gross underpayment ..." Basis for payment made is not stated in underlying Complaint.

International Center for Minimally Invasive Spine Surgery v. Horizon Blue Cross Blue Shield of New Jersey, U.S.D.C. D. NJ, Doc. No. 2:17-cv-07541-SDW-LDW, (filed Sept. 27, 2017). Provider and alleged assignee contends a patient underwent surgical treatment in its facility ("cervical discectomy and fusion procedures among other surgical procedures of the cervical spine"). Plaintiff submitted a HICF claim for in the amount of $243,384. "Defendant, however, only remitted payment in the amount of $7,539 ..." Basis for payment made (underpayment) is not evident from Complaint. Other actions filed by this provider reported in **MCLU Vol. 70, 71, 87**.

SEE ALSO:
International Center for Minimally Invasive Spine Surgery v. Horizon Blue Cross Blue Shield of New Jersey, U.S.D.C. D. NJ, Doc. No. 2:17-cv-07569-CCC-MF, (filed Sept. 28,

2017). Provider and alleged assignee contends a patient underwent surgical treatment in its facility ("lumbar discectomy and fusion procedures"). Plaintiff submitted a HICF claim for in the amount of $189,700. "Defendant, however, denied Plaintiff reimbursement pursuant to its determination that the above referenced treatment was not medically necessary."

University Spine Center, on assignment of Shyqyri T. v. Empire Blue Cross Blue Shield, U.S.D.C. D. NJ, Doc. No. 2:17-cv-07573-SDW-LDW, (filed Sept. 28, 2017). Provider and alleged assignee contends it rendered medical service to patient, ("posterior interlaminar decompression with laminectomies, among other surgical procedures of the lumbar spine"). Plaintiff submitted a HICF claim for in the amount of $159,308. "Defendant, however, only allowed reimbursement totaling $2,956.94 ..." Basis for payment made (underpayment) is not evident from Complaint.

Garrick Cox MD LLC v. UnitedHealthcare Insurance Company, U.S.D.C. D. NJ, Doc. No. 2:17-cv-07619-ES-JAD, (filed Sept. 28, 2017). Removed action which physician seeks recovery of $301,727.97 in benefits on behalf of 9 patients upon whom he performed surgery. Plaintiff alleges he received some payment "but not the correct amount." No other details regarding the procedure(s) or alleged underpayments are evident from the underlying Complaint. Another action filed by this provider and covered in **MCLU Vol. 61**.

SEE ALSO:
Garrick Cox MD LLC v. Empire Blue Cross Blue Shield, U.S.D.C. D. NJ, Doc. No. 2:17-cv-07628-MCA-MAH, (filed Sept. 28, 2017). Removed action which physician seeks recovery of $155,047.42 in benefits on behalf of 4 patients upon whom he performed surgery. Plaintiff alleges he received some payment "but not the correct amount." No other details regarding the procedure(s) or alleged underpayments are evident from the underlying Complaint.

Accelerated Collection Services, Inc. v. Sandra L. Hause, et al. v. Premera, U.S.D.C. W.D. WA, Doc. No. 2:17-cv-01473, (filed Sept. 28, 2017). Removed action in which defendants and third-party plaintiffs in the main demand (collection action for health expenses) seek recovery from Premera, alleging Premera unreasonably denied coverage for health expenses. No other details are available from the underlying Third-Party Complaint.

Alexis Maya Casagrade v. United Healthcare Insurance Company, U.S.D.C. D. CO, Doc. No. 1:17-cv-02372, (filed Sept. 29, 2017). Member seeks recovery of benefits associated with hospitalization for bacterial infection at Stoney Brook University (approx. $55,000) and Southampton Hospital (approx. $35,000). Denial for Southampton billing was predicated on the plaintiff not being covered under the Plan at the time the claim was processed and, in a subsequent statement, "because Southampton had not submitted its claim within the contractual time limits for doing so." Basis for nonpayment of Stoney Brook charges is not stated, although suggested for same reason as Southampton nonpayment.

Thomas Popovich v. Cigna Health and Life Insurance Company, U.S.D.C. D. CO, Doc. No. 1:17-cv-02357-MEH, (filed Sept. 29, 2017). Removed action in which plaintiff seeks recovery of benefits associated with "a heart related event for which he was treated at Penrose St. Francis Hospital in Colorado Springs, Colorado." "The billings … [were] denied for the stated reason that Mr. Popovich's coverage had been terminated." Plaintiff responds that all of his premium payments were timely made "and he is aware of no reason why his coverage should have or would have been terminated."

Third Quarter, 2017 Recap:

In the Third Quarter of 2017, these pages have covered 148 new claims including –

- 4 cases alleging a violation of the federal Mental Health Parity Act (or its state law equivalent) and 2 cases alleging a violation of the Affordable Care Act;
- 4 cases seeking coverage for wilderness programs;
- 4 cases involving a health insurer's recoupment efforts;
- 13 cases seeking coverage for treatment at residential treatment centers;
- 9 putative class actions; and
- 30 cases where coverage was sought contending the treatment was emergent (versus 25 cases in the Second Quarter 2017.

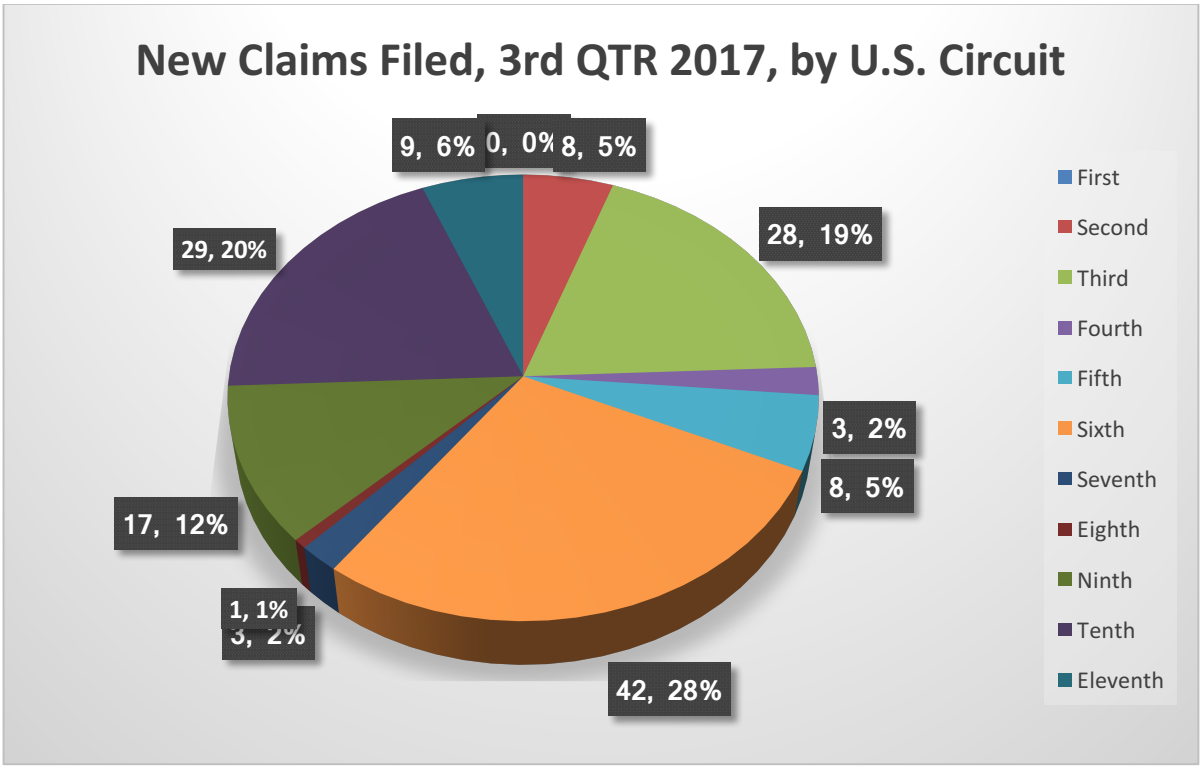
Judicial Facts, since January 2016:

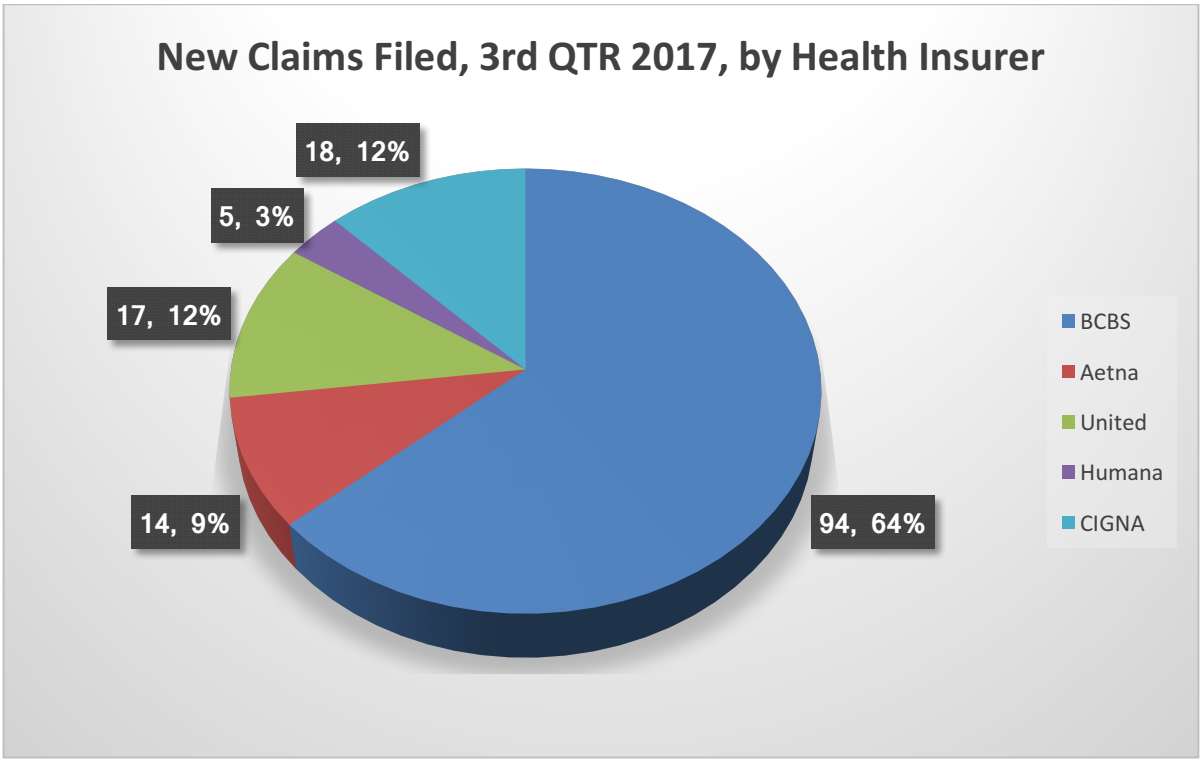
- Judge Dustin B. Pead, District Court of Utah, has the most number of managed care litigation matters followed by this publication: 16. Judge Evelyn J. Furse, also in the District Court of Utah, has been allotted the second highest number of managed care litigation matters: 12. That Court sees a high number of cases where mental health benefits are contested.
- The following Judges have been allotted a slightly lesser number of cases following by this publication, since January 2016: Judge Susan D. Wigenton, D. NJ (11), Judge David Nuffer, D. UT (11), Judge Maxine M. Chesney, N.D. CA (11), Judge Jill N. Parrish, D. UT (10), Judge Paul M. Warner, D. UT (9), and Judge Claire C. Cecchi, D. NJ (9).
- Judge Joan N. Ericksen, D. MN, has presided over the most number of reported managed care litigation class actions: 8.

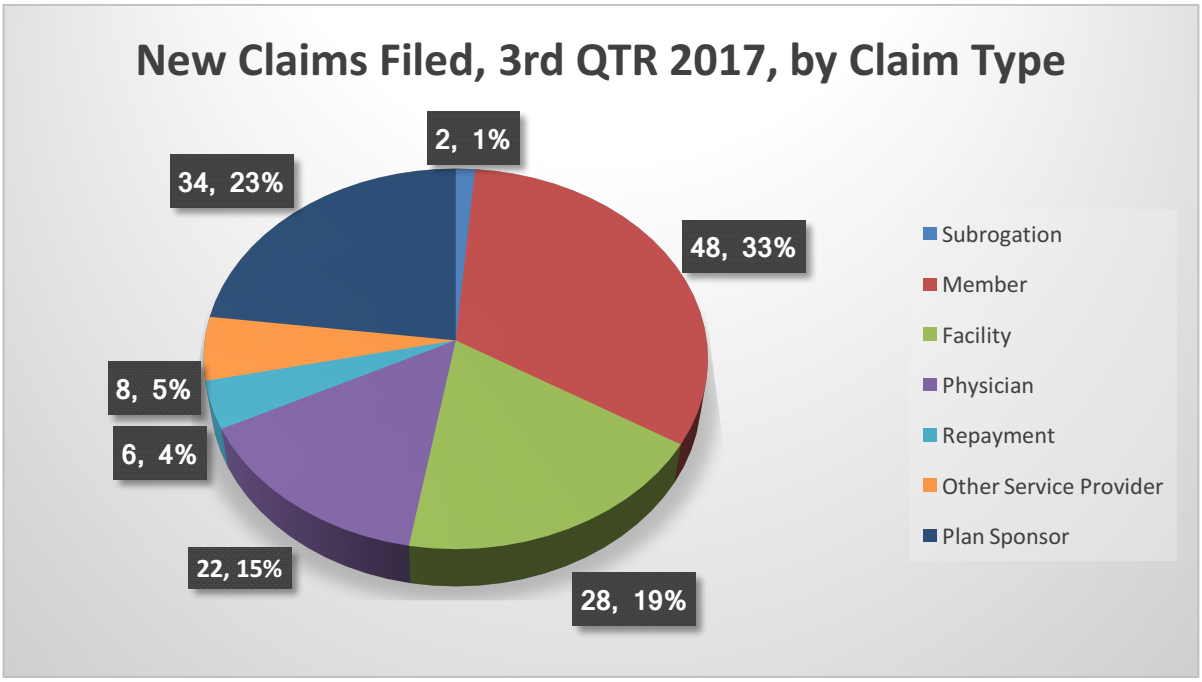
  Searching by judge, district court, key word search of case description, etc. is available to **Premium Subscribers**.

  JMH

Third Quarter 2017 Statistics.







SUMMARY:

- 148 new claims filed the Third Quarter, 2017.
- The largest concentration of new claims was in the Sixth Circuit, with 42 new claims, followed by the Tenth Circuit, with 29 new claims.
- BCBS (all plans) received the largest number of new claims (94), followed by CIGNA with 18 new claims. Claims against BCBS are slightly skewed due to the high number of Plan Sponsor claims.
- Member claims were the largest type of claims (48), followed by Plan Sponsor claims (34), then Facility claims (28).

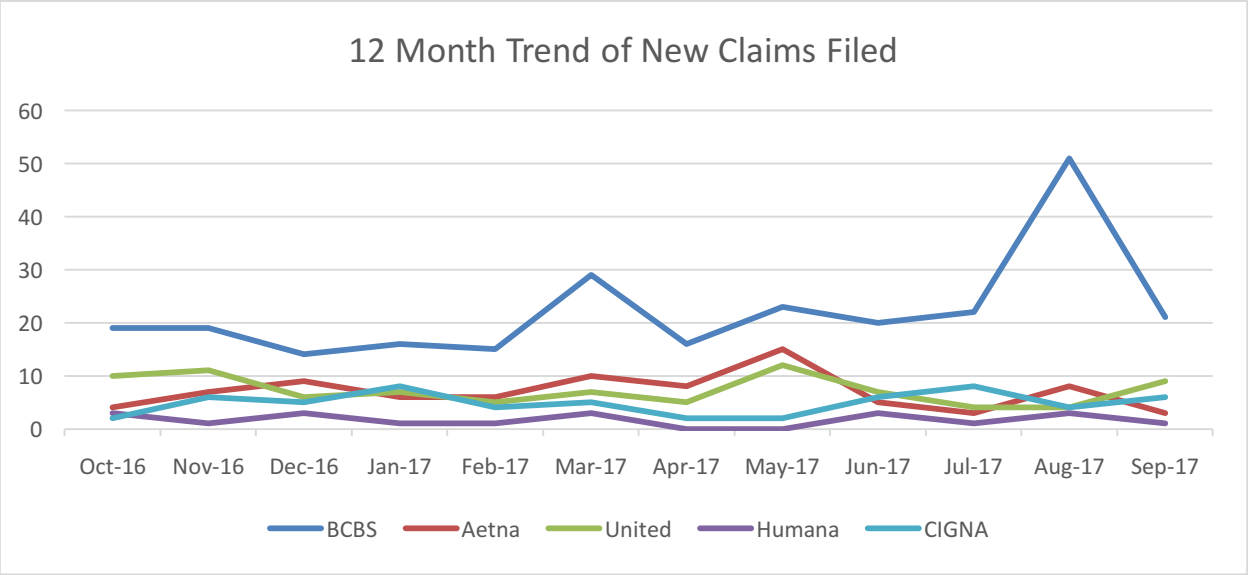
Compared to **last quarter**, Second Quarter, 2017:

- 124 new claims filed the Second Quarter, 2017.
- The largest concentration of new claims was in the Fifth Circuit, with 24 new claims, followed by the Ninth and Tenth Circuits, each with 21 new claims.
- BCBS (all plans) received the largest number of new claims (59), followed by Aetna with 28 new claims.
- Member claims were the largest type of claims (60), followed by Physician claims (22), then Facility claims (20).

Compared to **one year ago**, Third Quarter, 2016:

- 138 new claims filed the Third Quarter, 2016.
- The largest concentration of new claims was in the Ninth and Tenth Circuits, each with 26 new claims, followed by the Fifth Circuit, with 20 new claims.
- BCBS (all plans) received the largest number of new claims (61), followed by United with 29 new claims.
- Member claims were the largest type of claims (54), followed by Facility claims (30), then Physician claims (24).

Twelve Month trending of case filings.



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Mr. Herman is on the Roster of Arbitrators for the American Arbitration Association (Healthcare, Commercial) and a Neutral for the American Health Lawyers Association.

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