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Managed Care Litigation Update®

NEWSWORTHY

U.S. Seventh Circuit affirms dismissal on summary judgment of claims by debt collector assignees of Medicare Secondary Payor Act claims received from MAOs. Plaintiffs "failed to find within their basket of assigned receivables an example of a concrete and definite amount owed," earning a warning from the Court that "plaintiffs should think hard before risking a third strike within our Circuit." *MAO-MSO Recovery II, LLC, et al. v. State Farm Mutual Automotive Insurance Company*, USAC 7th Cir., No. 20-1268, (Doc. 44, filed Apr. 20, 2021).

District Court dismisses putative class action asserting an unlawful commission relationship pertaining to sale of AARP Medigap policies, holding the filed-rate doctrine bars plaintiffs' claims. *Brian Gozdenovich v. [ ], Unitedhealth Group, Inc., et al.*, USDC D. NJ, No. 2:18-cv-2788-MCA-MAH, (Doc. 209, filed Apr. 8, 2021).

District Court grants beneficiary summary judgment, ruling that ERISA plan wrongfully denied residential mental health benefits despite favorable external review. The court applied a *de novo* standard due to "extensive procedural irregularities." *Scott M., et. al, v. Blue Cross and Blue Shield of Massachusetts*, USDC D. UT, No. 1:17-cv-9-JCB, (Doc. 82, filed Mar. 24, 2021) (NOA filed Apr. 19, 2021). See also *MCLU Vol. 72*.

RECENTLY FILED ACTIONS

Removed action in which provider complains about a decision of a TDI arbitrator following an award of $2,165 on billed charges of $20,838. The claim had been submitted through Texas's mandatory arbitration regime. Other actions by this provider reported at *MCLU Vol. 151, 169, 170, 173*.

Please join me on June 9 – 10, 2021 at the ACI Managed Care Disputes and Litigation Virtual Conference, where I will be co-presenting "Building Better In-House and Outside Counsel Relationships: Industry Best Practices and Ethical Considerations." It promises to be an unparalleled learning experience. https://www.americanconference.com/managed-care-disputes-litigation/

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RECENTLY FILED ACTIONS

Member challenges subrogation claim for $80,172.62 following personal injury settlement associated with explosion, asserting that "Missouri law generally prohibits subrogation in personal injury cases."

OON Hospital seeks benefits and asserts underpayment. Billed charges were $2,047,769.76 and the amount paid was $78,771.30. Plaintiff asserts claims of breach of implied contract and quantum meruit.

Removed action in which member seeks benefits for air ambulance transport for infant child. The underlying complaint does not identify the grounds for denial.

Member seeks over $160,000 in ERISA benefits associated with residential inpatient treatment at Solacium Sunrise. Coverage was provided from April 13, 2017 through May 9, 2017 but denied thereafter. The denial asserted continued residential treatment was not medically necessary pursuant to the [ ] Level of Care Guidelines and common criteria for Mental Health Residential Treatment Center Level of Care.

Surgeon and alleged assignee seeks ERISA benefits and asserts underpayment associated with pre-authorized cervical spine surgery. Billed charges were $400,153 and the amount paid was $84,264.53. Other actions filed by this provider are reported in *multiple MCLU Vols*.

OON hospital and alleged assignee seeks $52,569.43 in ERISA benefits associated with heart ablation procedure. Plaintiff asserts [ ] indicated that a PA was not required and that it the hospital would be paid at 90% of billed charges, but "a significant portion" of the claim was denied as out of network. Other actions by this provider reported in multiple *MCLU Vols*.

Member seeks ERISA benefits for residential inpatient treatment at Viewpoint. The claim was denied as not meeting the Cigna Behavioral Medical Necessity Criteria for Residential Mental Health Treatment for Children and Adolescents.

Removed action in which member seeks ERISA benefits associated with $15,519 hospital bill and $8,719 surgeon bill following lap band procedure by OON provider. Plaintiff asserts pre-approval was provided on the grounds no in-network provider was available but that the claim was nonetheless denied as OON and not medically necessary.

Removed action in which member, through his physician as attorney in fact, seeks ERISA benefits and asserts underpayment for OON emergency surgery services. Billed charges were $257,560.82 and the amount paid was $215.91.

Member seeks ERISA benefits from self-funded plan associated with spinal surgery. The PA request was denied as not medically necessary.

Removed action in which member seeks ERISA benefits following treatment for injuries sustained in car accident. The underlying complaint does not state the grounds for denial.

Freestanding neurological surgery practice asserts antitrust claims on grounds of reimbursement rates. Plaintiff asserts [ ] has both refused to increase existing contractual rates and reduced the allowable amounts for OON providers. Other action by this provider reported in *MCLU Vol. 173*.

Removed action in which member seeks ERISA benefits associated with unspecified medical treatment. The grounds for denial are not identified in the underlying complaint.

Removed action in which OON physician and alleged assignee seeks over $1.8 million in ERISA benefits and asserts underpayment of emergency claims. Billed charges were $2,032,820.55 and the amount paid was $232,471.08. Other actions by this provider reported at *MCLU Vol. 163, 167, 168, 170, 173, 174*.

The Choctaw Nation, as owner of pharmacies under the Indian Health Care Improvement Act, alleges wrongful denials and underpayment by various PBMs inconsistent with 25 U.S.C. § 1621e.

Removed action in which member seeks ERISA benefits associated with emergency services after being balance billed. Member asserts claims of false advertising and unfair business practices pertaining to partial payment.

Member seeks over $100,000 in ERISA benefits associated with residential inpatient treatment at Telos. Coverage was provided from October 10, 2018 to October 16, 2018 but denied thereafter based on the [ ] Level of Care Guidelines for the Mental Health Residential Treatment Center Level of Care.

Putative class action in which members challenge denial of claim for embryo thawing in alleged violation of [state] insurance requirements for coverage of IVF. Members purchased an exchange policy. Claim was denied as "not a covered benefit/service."

Member seeks over $145,000 in ERISA benefits from self-funded plan associated with residential inpatient treatment at Elevations. Coverage was provided from August 14, 2018 through September 7, 2018 but denied thereafter as not medically necessary pursuant to the Psychiatric Disorder Treatment – Residential Treatment Center (RTC) CG-BEH-03.

Member seeks over $125,000 in ERISA benefits from self-funded plan associated with residential inpatient treatment at Fulshear Treatment to Transition and alleges violations of MHPAEA. The claim was denied as not medically necessary pursuant to the [ ] Behavioral Medical Necessity Criteria for Residential Mental Health Treatment for Adults.

Member seeks ERISA benefits associated with residential inpatient treatment at Spring Ridge Academy. Coverage was provided form January 13, 2018 through January 26, 2018 and denied thereafter. The response to appeal indicated the facility did not meet the RTC criteria because it did not have 24-hour on-site nursing.

Member seeks over $100,000 in ERISA benefits from self-funded plan associated with residential inpatient treatment at Telos. Coverage had been provided by a different insurer from January 29, 2018 through May 31, 2018 but denied thereafter by []. The claim was denied as excluded because it is a Wilderness Treatment Program.

ADDITIONAL NEWSWORTHY (REGULATORY)

Oklahoma Legislature expands prompt pay requirements to include a written notice to beneficiary and to provider including reason for denial or partial payment within 30 days from receipt of the claim. 2021 Okla. Sess. Law Serv. Ch. 200 (S.B. 550).

ABOUT THE AUTHOR

Jonathan M. Herman is the founding member of Herman Law Firm, which represents health insurers, plan administrators, and self-funded plans in reimbursement disputes and compliance matters. He is also 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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