Healthcare (Litigation, Regulatory & Transactional)

Our Healthcare team provides litigation, regulatory and transactional legal services to health insurers and providers in a variety of contexts.

d'QM's litigation team regularly represents large health insurers in all types of healthcare related matters including first party benefits and provider litigation, fraud, overpayments, subrogation, affirmative actions against "egregious billers" and enjoining these "egregious billers" from fraudulently "balance billing."

We are experienced in issues arising out of the business practices of the healthcare industry including hospital participation agreements, commercial, Medicare and Medicaid contracts, hospital networks, urgent care center claims, bundling, unbundling, downcoding, falsified claims, overpayment and underpayment issues, emergency room claims, in and out of network claims, HIPAA-related issues, and managed care litigation and arbitrations.

d'QM's health practice encompasses working directly with self-insured corporate clients. We look beyond the merits of the case to consider the overall cost of litigation and when appropriate, consider alternate methods to resolve disputes. We perform robust evaluations of cases early on to determine if cases are appropriate for early resolution and what is needed to potentially resolve the case so that unnecessary fees and expense are not incurred.

REPRESENTATIVE MATTERS

Provider Litigation

- Mediated advantageous settlements on behalf of insurers in several actions involving provider fraud.
- Represented health insurers in obtaining temporary restraining orders to recover egregious overpayments from insurer, and enjoining them from balance billing.
- Made successful motions to dismiss provider actions for lack of standing. Several were brought by providers who had been "red-flagged" by insurer, and in these instances, we brought successful counterclaims for fraud. Significantly, in two matters, the providers brought multimillion dollar lawsuits for denied claims. The insurer counterclaimed for fraud based on improper billing and also for overpayment based on waiver of co-insurance and deductibles.
- Obtained summary judgment dismissing provider claim for health benefits due to plaintiff's failure to exhaust administrative remedies and successfully opposed motion for summary judgment dismissing counterclaim to recover for fraudulent billing based on ERISA causes of action for unjust enrichment and equitable restitution.
- Obtained decision denying motion to remand based on assignment of claims to provider, and holding that ERISA preempted all of the state statutory and common law claims relating to claims under ERISA plans.
- Represented insurers in actions brought by non-participating providers seeking to avoid ERISA protections and standing issues by claiming negligent misrepresentation, and other torts allegedly unique to the providers.
- Resolved matter brought by provider against insurer for alleged improper denial of payments for minimally invasive foot surgery. Insurer brought counterclaims for fraud and unjust enrichment based on improper billing and waiver of co-insurance. Part of the settlement included the provider's agreement to collect co-insurance and deductibles and change certain of its billing practices.

Benefits Litigation

- Successfully litigated, through trial and appeal, a lawsuit challenging the reduction of skilled nursing benefits from twenty-four to two hours per day.
- Obtained summary judgment and denial of a motion for class certification in connection with a putative class action under New York State's Well Baby statute. Court rejected plaintiff's attempt to convert a single "approval error" into a reason to "justify a 'fishing expedition' through the files of all potential class plaintiffs."