Case No. 85525

IN THE SUPREME COURT OF NEVADA

UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTHCARE SERVICES, INC., d/b/a UNITEDHEALTCARE, a Minnesota corporation; UMR, INC., d/b/a UNITED MEDICAL RESOURCES, a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; and HEALTH PLAN OF NEVADA, INC., a Nevada corporation,

Appellants,

vs.

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM STEFANKO AND JONES, LTD., d/b/a RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation,

Respondents,

District Court Case No. A7292978, Department XXVII

RESPONDENTS' APPENDIX IN SUPPORT OF OPPOSITION TO UNITED'S MOTION TO EXTEND STAY OF DISTRICT COURT'S ORDER UNSEAING CERTAIN TRIAL EXHIBITS AND TRANSCRIPTS – VOLUME 2 OF 2

DENNIS L. KENNEDY, Nevada Bar No. 1462
SARAH E. HARMON, Nevada Bar No. 8106
BAILEY❖KENNEDY
8984 Spanish Ridge Avenue
Las Vegas, Nevada 89148-1302
Telephone: 702.562.8820
Facsimile: 702.562.8821
DKennedy@BaileyKennedy.com
SHarmon@BaileyKennedy.com

Attorneys for Respondents

November 10, 2022

JANE LANGDELL ROBINSON (*pro hac vice*)
JOHN ZAVITSANOS (*pro hac vice*)
JOSEPH Y. AHMAD (*pro hac vice*)
AHMAD, ZAVITSANOS & MENSING PC
1221 McKinney Street, Suite 2500
Houston, Texas 77010
Telephone: 713.600.4901
Facsimile: 713.655.0062
jrobinson@azalaw.com
jzavitsanos@azalaw.com
jahmad@azalaw.com

Attorneys for Respondents

RESPONDENTS' APPENDIX IN SUPPORT OF OPPOSITION TO UNITED'S MOTION TO EXTEND STAY OF DISTRICT COURT'S ORDER UNSEALING CERTAIN TRIAL EXHIBITS AND TRANSCRIPTS
VOLUME 2 OF 2

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EXHIBIT 3

EXHIBIT 3

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Sunday, November 7, 2021 7:19 PM
To: Blalack II, K. Lee; Ruth Deres; Michael Killingsworth; Myrna Flores
Cc: Yan, Jason; Plaza, Cecilia; Levine, Adam
Subject: RE: Partially Denied Claim Issue
Attachments: Stipulation and Order (003) KL.DOCX

[EXTERNAL MESSAGE]

Lee,

Here is my suggested edits to the stip.

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Friday, November 5, 2021 4:48 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Ruth Deres <rderes@AZALAW.COM>; Michael Killingsworth <mkillingsworth@AZALAW.COM>; Myrna Flores <mflores@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Levine, Adam <alevine@omm.com>
Subject: FW: Partially Denied Claim Issue

Kevin:

This revised list looks correct to us. We agree that this new exhibit contains the operative list of disputed claims. Accordingly, we think we can try the case based on this list.

The next step here is for our experts (Deal and Leathers) to revise their calculations to reflect this new and final list of disputed claims. As I mentioned in a prior email, I propose that the parties reach agreement on a process and timeline to amend those prior reports in a manner that reduces the possibility of disputes about what the experts are changing based on this final list. To that end, I am attaching a proposed stipulation and order for your consideration. The idea here is that the SAO would identify your new list as the operative list of disputed claims and it would also acknowledge that the parties' experts (Deal and Leathers) need to revise their calculations. It proposes a deadline of Wednesday, November 10th, to complete that process and makes clear that none of the experts can introduce any new opinions or methodologies; instead, they can merely perform the prior calculations in their reports using the final list of disputed claims.

In any event, take a look at the proposed SAO and let me know if this approach is acceptable to you all.

Best. Lee

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Friday, November 5, 2021 1:32 PM
To: Blalack II, K. Lee <lblalack@omm.com>
Cc: Ruth Deres <rderes@AZALAW.COM>; Michael Killingsworth <mkillingsworth@AZALAW.COM>; Myrna Flores <mflores@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Thanks Lee.

I gave Leathers the excel version to rerun his analysis and numbers. I've PDF'd this and would like to replace the current P473 with it. I've hidden some of the columns to make it easier to read on computer when zoom in and I"ve added column headings to each page.

Please let me know if you have any objections to this new version of P473.

thanks

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Friday, November 5, 2021 7:24 AM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>
Subject: FW: Partially Denied Claim Issue

Kevin,

My folks reviewed the spreadsheet you sent. There is one claim you've tagged as DiS which was not identified as non-DiS. That claim is Acct # 233718879/526.

Please let me know if you have any questions. Lee

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Wednesday, November 3, 2021 2:28 PM
To: Plaza, Cecilia <cplaza@omm.com>; Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Lee/Ceci,

I've added a column to this that tags what I believe are the iSight claims.

Please review and let me know if you have any issues with those designations.

Thanks

From: Plaza, Cecilia <cplaza@omm.com>
Sent: Sunday, October 31, 2021 3:35 PM

To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

Kevin,

We have reviewed and did not find any errors in the edits to the charge and CPT columns.

Thanks,
Ceci

Cecilia Plaza
O: +1-212-728-5962
cplaza@omm.com

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Sunday, October 31, 2021 1:55 PM
To: Plaza, Cecilia <cplaza@omm.com>; Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Lee/Ceci,

Here is an updated version of what I consider to be the final. I substituted the net charge (orig – denied) for the Total Charge column; and I also edited the CPT column to remove the denied CPTs.

Please review and let me know if you find any mistakes in either.
.

From: Plaza, Cecilia <cplaza@omm.com>
Sent: Sunday, October 31, 2021 11:05 AM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

Kevin,

We have reviewed your list and confirmed that, consistent with our discussions, all the relevant claims have been removed. We are in agreement that this is the final list of disputed claims. Please see attached a spreadsheet reflecting the final list of claims. Note that we deleted the extra columns ("KL delete claim" and "FAIR Health 80th"), renamed a few of the columns for clarity, and deleted the extra tab that shows denied billed charges for each disputed claim. It is otherwise the same as the spreadsheet you sent yesterday.

Thanks,

Ceci

Cecilia Plaza
O: +1-212-728-5962
cplaza@omm.com

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Saturday, October 30, 2021 9:04 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Per this discussion, I've removed those two other claims.

Please have your crew review and let me know if we've now removed all the claims consistent with these discussions.

If we are in agreement, I will produce just the claim file as 29011 (B).

K

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Saturday, October 30, 2021 8:37 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

Kevin,

Yes, not to belabor this issue, we will waive an ERISA claim based on partially denied claims if you remove these last two. That would resolve the issue that we raised in our SJ motion. That obviously does not result in waiver of other ERISA arguments that have nothing to do with a partially denied claim (e.g., basic conflict preemption, which is the argument that we presented originally in the case when we removed the case to federal court). We are preserving those other ERISA arguments but the removal of these last two partially denied claims would obviate the ERISA argument stated in our SJ motion.

Thanks. Lee

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Saturday, October 30, 2021 11:07 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Hmmm… if there is a 99291, 99292 claim and the 99292 was denied, but the 99291 claim was allowed and I've adjusted the ttl charge to reflect the denied charges, then how is it different than if the denied claim was a 93010 and I removed the denied charge for the 93010?

Regardless, if you are saying you are effectively walking away from ERISA arguments if I remove the 2 claims, then the answer to that riddle is obvious.

So what say you?

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Saturday, October 30, 2021 7:57 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

Not unless you are seeking to recover damages for the denied claim lines. The whole point of our proposal was to remove from your damages calculations any claims lines that were denied. If you all do that, and I think you have except for these last two, then it would mean that you are only seeking damages for underpayments of claims that were allowed at an amount less than full charges and you would not be seeking any damages for claim lines that were denied. If that is the case, while I might have other ERISA objections to this entire party, I don't think we would have an argument that you all were seeking to recover damages for a service as to which coverage was denied by my clients. Lee

---

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Saturday, October 30, 2021 6:09 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: Re: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Don't you have the erisa argument in all the other 1700 plus where a non core er code was denied?

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From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Saturday, October 30, 2021 2:49:39 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

Thanks Kevin. It looks this resolves all issues but the 2 remaining partially denied claims. I leave it to you all whether you want to keep these last two on your list. But just to be clear, if you leave them on the list, I still have my ERISA objection that there are coverage denials at issue in your damages calculation. If you remove them, I don't. Whether those two claims are worth it to you or not, I leave to your client and your judgment.

Let me know if you all want to stand pat on this list or remove those final two partially denied claims. Once we have the final list, we will send you our understanding of your final list of disputed claims. Perhaps you all can then review that list and confirm that we're in agreement that it is the final list of disputed claims for trial and we

can then enter a stipulation to that effect to help make sure our experts are not ships passing in the night with different disputed claims.

Lee

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Saturday, October 30, 2021 1:40 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Honest Abe, here is where I am.

I've noted all but the 2 (with 99291 allowed) should come out. And that's bc those partial denials are no different than all the others where a core EM line was not denied.

So now its your turn to say, ok we're there.

K

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Friday, October 29, 2021 8:25 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

I cannot tell a lie . . .

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Friday, October 29, 2021 11:07 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: Re: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

The question is clear.

Get Outlook for iOS

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Friday, October 29, 2021 8:02:22 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

Now, do I need to swear I wrote it all by myself? If not, I have my pinky ready to go . . .

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Friday, October 29, 2021 10:54 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: Re: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Lee,

If you pinky swear that you wrote this email, I will give further consideration to your requests.

Get Outlook for iOS

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Friday, October 29, 2021 6:18:10 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

Kevin,

Thanks for pulling this revised list together. We have reviewed your comments.

You identified 5 claims (rows 5, 8, 9, 13, and 14) which were part of the original 17 claims you noted that appeared to be allowed, but denied. As previously stated, these claims were denied in full. For all 17 of these claims, including the 5 you identified in your most recent spreadsheet, we reviewed PRAs, EOBs, or disallowed reason codes and confirmed that they were denied in full. Based on our review of your spreadsheet, it appears that TeamHealth may have recorded an allowed amount for these claims due to an amount being paid by the patient or simply due to error. Indeed, for most of these 5 claims, the allowed amount corresponds exactly to the amount of the patient deductible noted in your spreadsheet.

You also identified 2 claims with an ED CPT code that were not denied. We agree that these were not denied in full, but they were partially denied. You noted in row 11,508 that the 99291 claim line was still at issue, which is correct, but the 99292 claim line on that same claim was denied. Likewise, you noted in row 11,083 that the 99291 claim line was still at issue. Again, that is correct, but the 99292 claim line on that same claim was denied. So, these 2 claims are just like all of the other partially denied claims about which we have been conferring – there is a line on the claim that was paid and a line on the claim that was denied. The ERISA defense and issue we are raising does not turn on whether the denied claim line was an ER service or a non-ER service. It turns on whether the claim was fully approved and payable or whether the claim contains some claim lines that were denied as not covered and not payable. These two claims fall into that category. Let me know if you all see the data differently.

Finally, there are still 9 CollectRx resolved claims on this list (rows 11585 to 11594) which should be removed based on our prior discussion. Please let me know if you all see those 9 Collect Rx claims differently.

If we can reach agreement on these last group of claims, then I think we have a final list of disputed claims for trial and we can have our respective experts update their analysis based on this final list. Thanks. Lee

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Thursday, October 28, 2021 4:42 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Couple of issues with a few, but I think we are very close. Please review and let me know.

K

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Monday, October 25, 2021 8:07 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

Kevin,

Per your request, we have added a column (AD) to the spreadsheet showing the CPT codes for the denied charges. Please see attached.

Regarding the 18 account numbers in Bruce Deal's work papers: We have removed those from the list. In the initial spreadsheet, these claims were marked as denied but with denied charges of $0. It appears that either TeamHealth is not disputing the billed charges associated with the denied lines, or those line items were re-adjudicated later and United allowed some amount.

Regarding the 17 claims which appear to be denied in full: These claims are recorded as denied in full in Defendants' claims data. We have reviewed the denial reasons for these claims and they were indeed denied in full. While TeamHealth recorded an allowed amount for these claims, there is no corresponding allowed amount in Defendants' claims data. It is possible that the allowed amount recorded by TeamHealth was paid by the patient or a different payor; was recorded in error; or was the result of a claim initially being allowed but later reversed and denied.

Please let me know if you have further questions. Thanks. Lee

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Sunday, October 24, 2021 2:18 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Also, I note that the following 17 records, using your denied charges, suggest that the claim was denied in full, but if every one of them has an allowed amount, so that doesn't make sense to me.

DOS	ACCOUNT #	BILLED CPT (BUNDLED)	TOTAL CHARGE	CHARGE F	ALLOW	Lee Denie	Lee Denied Charge
7/12/2019	243523324/526	99283	510.00	-	185.00	Y	$510
7/31/2019	244445501/526	99283	508.00	-	185.00	Y	$508
11/21/2019	253083102/526	99283*X0066	508.00	-	112.44	Y	$508
10/19/2019	267845844/526	99284:SA*99053	1,019.00	-	214.51	Y	$1,019
6/27/2019	242549357/526	99284*99053	1,019.00	-	185.00	Y	$1,019
12/30/2019	256501044/526	99284	973.00	-	214.51	Y	$973
4/30/2019	238092469/526	99284	973.00	-	185.00	Y	$973
11/22/2019	260379513/526	99285:SA*99053:SA	1,474.00	-	315.25	Y	$1,474
1/14/2020	256857574/526	99285*99053	1,474.00	-	185.00	Y	$1,474
9/14/2019	247949711/526	99285	1,428.00	-	315.25	Y	$1,428
1/12/2020	256663800/526	99285	1,428.00	-	185.00	Y	$1,428
5/30/2019	240602924/526	99285	1,421.00	-	185.00	Y	$1,421
6/9/2018	214814153/526	99285:SA	1,360.00	-	315.25	Y	$1,360
7/15/2018	217423278/526	99285:SA	1,360.00	-	841.75	Y	$1,360
1/10/2020	256617535/526	99285	1,360.00	-	185.00	Y	$1,360
7/24/2019	244028178/471	99285:SA	1,138.00	-	368.78	Y	$1,138
8/3/2019	246698881/526	99291*99053	1,899.00	-	185.00	Y	$1,899

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Sunday, October 24, 2021 11:42 AM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>
Subject: RE: Partially Denied Claim Issue

Kevin,

We have now had the opportunity to review the spreadsheet that you sent on Thursday to address our objections to the disputed claims that contain coverage denials. Thanks to you all for taking a crack at solving this problem but, unfortunately, your proposed method of removing the denied claim lines doesn't solve the problem. Your approach assumes that all the primary ED CPT codes on these claims were allowed and paid, while all the secondary CPT codes were denied. This creates two problems: First, this approach excludes claim lines with secondary CPT codes that were allowed and paid. Second, this approach includes claim lines with ED CPT codes which were denied. It is therefore both over- and under-inclusive.

I want to propose an alternative way to solve the problem. We have prepared a spreadsheet that flags the denied claims (see attached spreadsheet column AB) and lists the amount of charges that were denied for each claim (see column AC). This spreadsheet accurately captures the charges actually denied for each claim. This method thus targets narrowly the issue of partial denials. It does not remove any claim lines that were paid and it removes all claim lines that were denied. Please share this analysis with Mr. Leathers and your broader team and let me know if they have any questions and, if they do, we would be willing to put our experts together with your experts to get aligned on this problem. If you all are willing to remove the denied claim lines from your damages analysis, which would be consistent with the position that your colleague communicated to Judge Allf at the hearing on our summary judgment motion last week, then I think this will resolve our objection about the partially denied claims on the disputed claims list.

By the way, please note that this spreadsheet already removes the claims conceded in Plaintiffs' opposition to Defendants' motion for partial summary judgment (i.e., UHC and UMR claims with a Jan 2020 DOS, claims resolved through negotiated agreements with DiS, the non-ER claims identified by Mr. Leathers for removal, and the 10 additional Data iSight claims about which we corresponded previously).

Best. Lee

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Thursday, October 21, 2021 5:56 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Lee, see enclosed. Per my text, I've added three columns to FESM 20911 (B) for the purpose of isolating the partially denied claims and once identified, extracting the core EM cpt so that when assessed for damages, column M (CPT FOR TRIAL (KL)) and column O (CHARGES FOR TRIAL (KL)) , will result in the same damage number regardless of whether that claim is measured against a bundled or unbundled cpt source file.

Also, I'm waiting to hear back from Louis as to the other 10 iSight claims. If we agree, those will come out to.

Expert will have to do math as well to see if they get same result and will also have to set the data in the "charge for trial column.

Let me know what you (Deal) thinks of this approach to resolving your concern that we are seeking damages for the denied claim lines associated with the bills that had a denied claim line.

K

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SAO

D. Lee Roberts, Jr., Esq.
Nevada Bar No. 8877
lroberts@wwhgd.com
Colby L. Balkenbush, Esq.
Nevada Bar No. 13066
cbalkenbush@wwhgd.com
Brittany M. Llewellyn, Esq.
Nevada Bar No. 13527
bllewellyn@wwhgd.com
Phillip N. Smith, Jr., Esq.
Nevada Bar No. 10233
psmithjr@wwhgd.com
Marjan Hajimirzaee, Esq.
Nevada Bar No. 11984
mhajimirzaee@wwhgd.com
WEINBERG, WHEELER, HUDGINS, GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
Telephone: (702) 938-3838
Facsimile: (702) 938-3864

Daniel F. Polsenberg, Esq.
Nevada Bar No. 2376
dpolsenberg@lewisroca.com
Joel D. Henriod, Esq.
Nevada Bar No. 8492
jhenriod@lewisroca.com
Abraham G. Smith, Esq.
Nevada Bar No. 13250
asmith@lewisroca.com
Lewis Roca Rothgerber Christie LLP
3993 Howard Hughes Parkway, Suite 600
Las Vegas, Nevada 89169-5996
Telephone: (702) 949-8200

Attorneys for Defendants

Dimitri D. Portnoi, Esq.(*Admitted Pro Hac Vice*)
dportnoi@omm.com
Jason A. Orr, Esq. (*Admitted Pro Hac Vice)*
jorr@omm.com
Adam G. Levine, Esq. *(Admitted Pro Hac Vice)*
alevine@omm.com
Hannah Dunham, Esq. *(Admitted Pro Hac Vice)*
hdunham@omm.com
Nadia L. Farjood, Esq. (*Admitted Pro Hac Vice*)
nfarjood@omm.com
O'Melveny & Myers LLP
400 S. Hope St., 18th Floor
Los Angeles, CA 90071
Telephone: (213) 430-6000

K. Lee Blalack, II, Esq.(*Admitted Pro Hac Vice)*
lblalack@omm.com
Jeffrey E. Gordon, Esq. *(Admitted Pro Hac Vice)*
jgordon@omm.com
Kevin D. Feder, Esq. *(Admitted Pro Hac Vice)*
kfeder@omm.com
Jason Yan, Esq. *(Admitted Pro Hac Vice)*
jyan@omm.com
O'Melveny & Myers LLP
1625 Eye St. NW
Washington, DC 20006
Telephone: (202) 383-5374

Paul J. Wooten, Esq. *(Admitted Pro Hac Vice)*
pwooten@omm.com
Amanda L. Genovese *(Admitted Pro Hac Vice)*
agenovese@omm.com
Philip E. Legendy *(Admitted Pro Hac Vice)*
plegendy@omm.com
O'Melveny & Myers LLP
Times Square Tower, Seven Times Square
New York, NY 10036
Telephone: (212) 728-5857

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs,	Case No.: A-19-792978-B Dept. No.: 27 **STIPULATION AND ORDER REGARDING REVISING THE PARTIES' EXPERT REPORTS USING THE FINAL DISPUTED CLAIMS LIST**

vs.

UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation,

Defendants.

Plaintiffs Fremont Emergency Services (Mandavia), Ltd; Team Physicians of Nevada-Mandavia, P.C.; Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine (collectively "Plaintiffs") and Defendants UnitedHealthcare Insurance Company; United HealthCare Services, Inc.; UMR, Inc.; Sierra Health and Life Insurance Company, Inc.; and Health Plan of Nevada, Inc. (collectively "Defendants"), referred to individually as a "Party" or collectively as the "Parties," stipulate and agree to the following:

WHEREAS, the Plaintiffs produced an initial list of disputed claims in this case, FESM000011, marked as Defendants' Exhibit 4686, and thereafter produced various amended lists of disputed claims.

WHEREAS, following the parties' joint efforts to confer and remove certain claims from the various lists produced to date, Plaintiffs produced a final amended list of disputed claims (FESM 000291 (B), marked as Plaintiffs' Exhibit 473.

WHEREAS, the Defendants dispute liability for the claims identified by the Plaintiffs in Plaintiffs' Exhibit 473, but agree that Plaintiffs' Exhibit 473 contains the operative list of claims in dispute for trial.

WHEREAS, the Parties' experts previously produced reports based on prior versions of the operative disputed claim file.

WHEREAS, the Parties agree that their respective experts (Bruce Deal for Defendants and David Leathers for Plaintiffs should revise their analysis and calculations using the final claims data reflected in Plaintiffs' Exhibit 473.

THEREFORE, THE PARTIES AGREE AND STIPULATE AS FOLLOWS:

1. Plaintiffs' Exhibit 473 contains the operative list of claims in dispute for trial and shall be admitted into evidence for all purposes.

2. The Parties' respective experts (Defendants' expert witness Bruce Deal will and Plaintiffs' expert witness David Leathers) will amend their reports where appropriate to include revised calculations based on the operative disputed claims list reflected in Plaintiffs' Exhibit 473.

3. The Parties will exchange such amended reports by _____.

4. When revising their reports, both Parties' experts will use the same methodologies as those contained in their prior reports.

DATED this 5th day of November, 2021.

AHMAD, ZAVITSANOS, ANAIPAKOS, ALAVI & MENSING, P.C

By: /s/ _____
Joseph Y. Ahmad (*Pro Hac Vice*)
John Zavitsanos (*Pro Hac Vice*)
Jason S. McManis (*Pro Hac Vice*)
Michael Killingsworth (*Pro Hac Vice*)
Louis Liao (*Pro Hac Vice*)
Jane L. Robinson (*Pro Hac Vice*)
Patrick K. Leyendecker (*Pro Hac Vice*)
1221 McKinney Street, Suite 2500
Houston, Texas 77010
joeahmad@azalaw.com
jzavitsanos@azalaw.com
jmcmanis@azalaw.com
mkillingsworth@azalaw.com

DATED this 5th day of November, 2021.

O'MELVENY & MYERS LLP

By: /s/ _____
Dimitri D. Portnoi, Esq. (*Pro Hac Vice*)
Jason A. Orr, Esq. (*Pro Hac Vice*)
Adam G. Levine, Esq. (*Pro Hac Vice*)
Hannah Dunham, Esq. (*Pro Hac Vice*)
Nadia L. Farjood, Esq. (*Pro Hac Vice*)
O'Melveny & Myers LLP
400 S. Hope St., 18th Floor
Los Angeles, CA 90071

K. Lee Blalack, II, Esq. (*Pro Hac Vice*)
Jeffrey E. Gordon, Esq. (*Pro Hac Vice*)
Kevin D. Feder, Esq. (*Pro Hac Vice*)
Jason Yan, Esq. (*Pro Hac Vice*)
O'Melveny & Myers LLP
1625 Eye St. NW
Washington, DC 20006

lliao@azalaw.com
jrobinson@azalaw.com
kleyendecker@azalaw.com

Pat Lundvall (NSBN 3761)
Kristen T. Gallagher (NSBN 9561)
Amanda M. Perach (NSBN 12399)
McDONALD CARANO LLP
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
Telephone: (702) 873-4100
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiffs

Paul J. Wooten, Esq. (*Pro Hac Vice*)
Amanda L. Genovese, Esq. (*Pro Hac Vice*)
Philip E. Legendy, Esq. (*Pro Hac Vice*)
O'Melveny & Myers LLP
Times Square Tower, Seven Times Square
New York, NY 10036

D. Lee Roberts, Jr. (NSBN 8877)
Colby L. Balkenbush (NSBN 13066)
Brittany M. Llewellyn (NSBN 13527)
Phillip N. Smith, Jr., Esq.
Marjan Hajimirzaee, Esq.
WEINBERG, WHEELER, HUDGINS
GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
Telephone: (702) 938-3838

Daniel F. Polsenberg, Esq.
Joel D. Henriod, Esq.
Abraham G. Smith, Esq.
Lewis Roca Rothgerber Christie LLP
3993 Howard Hughes Parkway
Suite 600
Las Vegas, Nevada 89169-5996
Telephone: (702) 949-8200

Attorneys for Defendants

ORDER

IT IS SO ORDERED that pursuant to the Parties' agreement, the Parties may file amended expert reports from their expert witnesses: Defendants' expert witness Bruce Deal and Plaintiffs' expert witness David Leathers. The Parties will file their amended expert reports by no later than November 10, 2021. The Parties' amended expert reports will not contain new opinions or new methodologies that differ from those contained in their respective prior expert reports. The sole purpose of these amendments is to amend prior calculations to account for changes in the list of disputed claims asserted by Plaintiffs, as reflected in Plaintiffs Ex. #.

DATED this __ day of November, 2021.

Respectfully Submitted by:
WEINBERG, WHEELER, HUDGINS,
GUNN & DIAL, LLC
By: /s/ _____
D. Lee Roberts, Jr. (NSBN 8877)
Colby L. Balkenbush (NSBN 13066)
Brittany M. Llewellyn (NSBN 13527)
Attorneys for Defendants

EXHIBIT 4

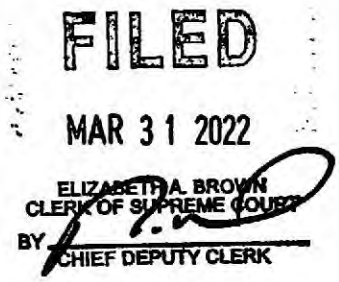
EXHIBIT 4

138 Nev., Advance Opinion 17

IN THE SUPREME COURT OF THE STATE OF NEVADA

BARRY JAMES RIVES, M.D.; AND LAPAROSCOPIC SURGERY OF NEVADA, LLC,
Appellants/Cross-Respondents,
vs.
TITINA FARRIS; AND PATRICK FARRIS,
Respondents/Cross-Appellants.

No. 80271



BARRY JAMES RIVES, M.D.; AND LAPAROSCOPIC SURGERY OF NEVADA, LLC,
Appellants,
vs.
TITINA FARRIS; AND PATRICK FARRIS,
Respondents.

No. 81052

Consolidated appeals and a cross-appeal from a district court judgment in a medical malpractice action and a post-judgment order awarding attorney fees and costs. Eighth Judicial District Court, Clark County; Joanna Kishner, Judge.

Reversed in part, vacated in part, and remanded.

Lemons, Grundy & Eisenberg and Robert L. Eisenberg, Reno,
for Appellants/Cross-Respondents.

Claggett & Sykes Law Firm and Micah S. Echols, Las Vegas; Hand & Sullivan, LLC, and George F. Hand, Las Vegas; Bighorn Law and Kimball J. Jones and Jacob G. Leavitt, Las Vegas,
for Respondents/Cross-Appellants.

BEFORE THE SUPREME COURT, EN BANC.

OPINION

By the Court, CADISH, J.:

Appellants appeal from a $6 million judgment, challenging several evidentiary rulings they claim warrant reversal and remand for a new trial. Respondents assert that because appellants did not move for a new trial in district court, they waived the issues, such that their assignments of error on appeal cannot provide the basis for a new trial. Respondents fail to present a convincing argument that the procedural bars they claim prohibit our review on the merits apply here. The plain language of our jurisdictional rules confirms that appellants are not required to file a motion for a new trial in district court to preserve their ability to request a new trial on appeal. As to the merits of appellants' claims, we conclude that the district court abused its discretion by admitting evidence of another medical malpractice case against appellant Barry James Rives, M.D., as that evidence was not relevant for an admissible purpose, and any potential relevance was substantially outweighed by the evidence's fairly obvious prejudicial effect. As this evidentiary ruling was harmful, we reverse the judgment, vacate the attorney fees and costs order, and remand for a new trial.

FACTS AND PROCEDURAL HISTORY

Respondent Titina Farris suffered from back pain with pain and burning in her feet. She was diagnosed with uncontrolled diabetes causing neuropathy. In 2014, Farris was referred to appellant Barry James Rives, M.D., for swelling in her upper abdomen. Rives diagnosed Farris with a hernia, which he surgically repaired on two occasions, first in 2014

and second in 2015. During the second surgery, Rives noticed that part of Farris's colon was stuck in the mesh from the 2014 surgery. Rives freed the colon from the mesh; however, he caused two small holes in the colon, which he repaired with a stapling device. Farris had several problems following the 2015 surgery, including sepsis. Although a CT scan on July 5 and an x-ray on July 12 showed no signs of a leak in Farris's colon, a CT scan on July 15 showed a leak, which another surgeon corrected. But Farris's sepsis continued, and she eventually developed drop foot in both feet, hindering her ability to walk unassisted. Farris and her husband, respondent Patrick Farris (collectively "respondents"), filed this medical malpractice lawsuit against Rives and appellant Laparoscopic Surgery of Nevada LLC (collectively "appellants"), alleging that Rives fell below the standard of care in performing the surgery and monitoring Farris after, that Laparoscopic Surgery of Nevada LLC was vicariously liable for Rives's actions, and for loss of consortium.

In an unrelated matter, another patient, Vickie Center, sued Rives for malpractice related to her hernia surgery, which took place five months before Farris's surgery. The same defense firm represented Rives in both the *Farris* and *Center* cases. In the *Center* case, Rives responded to an interrogatory that asked him to provide information concerning other lawsuits in which he was involved. One month later, Rives responded to a similar interrogatory request in the *Farris* case, and his attorney copied the interrogatory responses from the *Center* case without adding the *Center* case to the list of other suits.

Respondents' counsel deposed Rives. At the deposition, counsel asked questions regarding the other cases Rives disclosed in his interrogatory response. Rives's responses did not mention the *Center* case,

but defense counsel interjected with information about that case. Rives was then asked several questions regarding the *Center* case, and respondents' counsel discussed the *Center* case with Center's counsel "weeks to months before the trial in" the *Center* case started.

Before the trial in this matter, respondents filed a pretrial motion for sanctions, contending that Rives intentionally concealed the *Center* case. Respondents asserted that they "had no reasonable opportunity to further investigate this critical and admissible information" and requested that the district court strike appellants' answer. Appellants opposed, arguing that the omission was accidental and there was no prejudice to respondents. They also argued that the *Center* case was not admissible, as it was irrelevant, unduly prejudicial, misleading to the jury, and improper character evidence.

The district court held an evidentiary hearing on the motion, at which Rives testified that he relied on his counsel to prepare the interrogatory responses in the *Farris* case and conceded that he did not read them. The district court concluded that Rives "relied on counsel" to prepare the interrogatory responses and, thus, had "an intent not to read the interrogatories," which the court considered "intentional conduct" warranting an adverse-inference instruction.[1] While the district court

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[1]Ultimately, the district court read the following adverse-inference instruction before the opening statements and at the end of trial:

> Members of the jury, Dr. Barry Rives was sued in a medical malpractice case in case *Vickie Center v. Barry James Rives, M.D., et al.* Dr. Barry Rives was asked about the *Vickie Center* case under oath, and he did not disclose the case in his interrogatories or at his deposition. You may infer

permitted respondents to introduce evidence of the *Center* case, it did not make an express ruling on its admissibility until trial.

At trial, respondents mentioned the *Center* case roughly 180 times in front of the jury. Appellants objected several times, on various grounds, including that the evidence was irrelevant and that the danger of unfair prejudice, confusion of the issues, or misleading the jury substantially outweighed the probative value of the *Center* case. While the district court sustained some objections, it often allowed respondents to point to the *Center* case in making arguments or questioning witnesses. Respondents used the *Center* case to imply that Rives should have known his behavior was negligent and hinted that Rives had a propensity to commit malpractice. Respondents elicited that Vickie Center lost her legs because of Rives's actions. The district court allowed an extended examination of Rives regarding whether he informed Center's counsel of the specifics of the *Farris* case and the extent of Vickie Center's similar injuries. Respondents also mentioned the *Center* case in their closing argument.

The jury returned its verdict, concluding that Rives negligently treated Farris, causing her injuries, and awarding respondents $13,640,479.90 in total damages. The district court reduced the jury's award of noneconomic damages to $350,000 pursuant to NRS 41A.035 and entered a judgment for a total of $6,367,805.52. The district court granted in part respondents' motion for attorney fees and costs, awarding

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> that the failure to timely disclose evidence of a prior medical malpractice lawsuit against Dr. Barry Rives is unfavorable to him. You may infer that the evidence of the other medical malpractice lawsuit would be adverse to him in this lawsuit had he disclosed it. This instruction is given pursuant to a prior [c]ourt ruling.

$821,468.66 consistent with NRCP 68 and NRS 7.095, or alternatively, as a sanction for Rives's discovery behavior. Appellants appeal from the judgment and the attorney fees and costs award, while respondents cross-appeal from the judgment to contest the district court's application of NRS 41A.035.

DISCUSSION

Appellants did not waive their right to seek reversal and remand for a new trial on appeal by not filing a motion for a new trial in district court

Appellants assert that the district court committed evidentiary errors warranting reversal and remand for a new trial. Respondents argue that by failing to file a motion for a new trial in district court, appellants waived their ability to request a new trial on appeal. Respondents contend that the failure to seek a new trial in district court deprives the court of the chance to consider and correct any errors and prevents this court from "conduct[ing] a proper review of whether the [d]istrict [c]ourt properly or improperly granted a new trial because there is no appealable order to review." They further argue that appellants "ask this Court to review, in the first instance, their arguments for a new trial, which contain factual issues and would convert this Court into a factfinder." We disagree.[2]

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[2]Relying on *Rust v. Clark County School District*, 103 Nev. 686, 747 P.2d 1380 (1987), respondents also argue that we lack jurisdiction to consider appellants' challenges to the district court's oral evidentiary rulings made at trial. In *Rust*, we held the following:

> An oral pronouncement of judgment is not valid for any purpose. therefore, only a written judgment has any effect, and only a written judgment may be appealed. The district court's oral pronouncement from the bench, the clerk's minute order, and even

While we have not explicitly addressed whether a party must both object to trial rulings and file a motion for a new trial to preserve the party's ability to request a new trial on appeal, the plain language of our jurisdictional rule and the preserved error rule make it clear that a party is not required to file a motion for a new trial to preserve the party's ability to request such a remedy on appeal for harmful error to which the party objected. First, NRAP 3A(a) expressly provides that "[a] party who is aggrieved by an appealable judgment or order may appeal from that judgment or order, with or without first moving for a new trial." The rule thus contemplates this very situation. Second, it is well-established that a timely objection alone is sufficient to raise and preserve an issue for appellate review. *See Thomas v. Hardwick*, 126 Nev. 142, 155, 231 P.3d 1111, 1120 (2010) (concluding that when a trial court properly declines to

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> an unfiled written order are ineffective for any purpose and cannot be appealed.

Id. at 689, 747 P.2d at 1382 (internal citations omitted). However, *Rust* dealt with a premature notice of appeal filed prior to the district court entering a written, final judgment and is plainly inapplicable here, where appellants are appealing from a final, written judgment. *Cf. Consol. Generator-Nev., Inc. v. Cummins Engine Co.*, 114 Nev. 1304, 1312, 971 P.2d 1251, 1256 (1998) (explaining that this court will review interlocutory decisions that "are not independently appealable" in an appeal from a final judgment). Moreover, NRS 47.040 provides both the authority and framework for addressing alleged error in evidentiary rulings, depending on whether a party preserved error through objection, as we have recognized in various cases. *See, e.g., Rimer v. State*, 131 Nev. 307, 332, 351 P.3d 697, 715 (2015) (explaining that a party preserves a claim of error by objecting and stating the grounds for the objection at trial); *In re J.D.N.*, 128 Nev. 462, 468-69, 283 P.3d 842, 846-47 (2012) (observing that the scope of review depends on whether a party preserved error by objecting to the admission of evidence). Thus, we have the ability to review appellants' evidentiary challenges, and nothing in *Rust* precludes our review.

give a definitive ruling on a pretrial motion, the contemporaneous objection rule requires the party to object at trial in order to preserve its argument on appeal); *Landmark Hotel & Casino, Inc. v. Moore*, 104 Nev. 297, 299, 757 P.2d 361, 362 (1988) ("[F]ailure to object to a ruling or order of the court results in waiver of the objection and such objection may not be considered on appeal."); *see also* NRS 47.040(1)(a) (requiring "a timely objection or motion to strike . . . stating the specific ground of objection" to preserve the issue for appeal); *cf. In re J.D.N.*, 128 Nev. 462, 468, 283 P.3d 842, 846 (2012) (explaining that a party preserves a claim of error by objecting and stating the grounds for the objection at trial). Taken together, these authorities make clear that a party need not file a motion for a new trial to raise a preserved issue on appeal or request a new trial as a remedy for alleged errors below. Such a holding is consistent with both the federal approach and our past decisions considering a preserved error without the appellant having moved for a new trial below.[3] *See, e.g.*, *Richardson v. Oldham*, 12 F.3d 1373, 1377 (5th Cir. 1994) ("Filing a Rule 59 motion is not a prerequisite to taking an appeal . . . ."); *Floyd v. Laws*, 929 F.2d 1390, 1400-01 (9th Cir. 1991) ("A question raised and ruled upon need not be raised again on a motion for a new trial to preserve it for review.");

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[3]While NRAP 3A(a) does not require a party move for a new trial prior to bringing an appeal, we note that there are several practical benefits to doing so. First, it allows the district court to correct alleged errors, which allows for the prompt resolution of a case without potentially unnecessary appellate litigation. Second, it develops a better record for appellate review as the parties crystalize their arguments while giving the district court an opportunity to fully articulate the reasoning for its evidentiary rulings. Thus, while not required, moving for a new trial prior to pursuing an appeal provides distinct benefits that litigants should consider prior to bringing an appeal.

LaBarbera v. Wynn Las Vegas, LLC, 134 Nev. 393, 398, 422 P.3d 138, 142 (2018) (concluding the district court abused its discretion by excluding certain pieces of evidence and remanding for a new trial without mentioning whether the appellant filed a motion for a new trial before pursuing the appeal).

Respondents' contrary arguments are not persuasive, as the Nevada cases on which they rely are either inapposite or distinguishable. Neither *Old Aztec Mine, Inc. v. Brown*, 97 Nev. 49, 623 P.2d 981 (1981), nor *Schuck v. Signature Flight Support of Nevada, Inc.*, 126 Nev. 434, 245 P.3d 542 (2010), require a motion for a new trial as a prerequisite to filing an appeal regarding an otherwise preserved error. In *Old Aztec*, this court declined to consider the appellant's argument regarding its counterclaim because it failed "to direct the trial court's attention to its asserted omission to mention the counterclaim expressly in its judgment." 97 Nev. at 52-53, 623 P.2d at 983-84. It thus determined that the waiver doctrine rendered the claim of unpreserved error unreviewable. In *Schuck*, the appellant challenged summary judgment by raising several new legal arguments, which this court refused to consider for the first time on appeal. 126 Nev. at 436-38, 245 P.3d at 544-45. Neither case addressed whether a motion for a new trial is required to preserve a claim of error for appellate review. Further, the cases from other jurisdictions to which respondents point are factually dissimilar in that the appellants either failed to preserve their appellate arguments with timely objections at trial or the jurisdictions, unlike Nevada, have procedural rules requiring a new trial motion before appealing. *See, e.g., State v. Davis*, 250 P.2d 548, 549 (Wash. 1952) (concluding that the appellant, who failed to object at the time the prejudicial conduct occurred or to preserve the issue raised on appeal in any

way, waived his argument, while observing that a new trial motion gives "the trial court an opportunity to pass upon questions not before submitted for its ruling" without addressing whether the appellant would be required to seek a new trial if he had objected to the prejudicial conduct during trial); *Spotts v. Spotts*, 55 S.W.2d 977, 980 (Mo. 1932) (applying a Missouri statute in concluding that appellant must object and file a new trial motion to preserve a "writ of error" challenge to a jury verdict). Accordingly, appellants did not need to move for a new trial below to raise preserved issues on appeal or to request a new trial as an appellate remedy for those alleged errors.[4]

The district court abused its discretion by allowing evidence of the Center *malpractice case, and the error is not harmless*

Appellants argue that the district court abused its discretion in admitting evidence of the *Center* case because that evidence is irrelevant, since an unrelated, prior medical malpractice suit does not address whether Rives's conduct in this specific case fell below the applicable standard of care. They further contend that the *Center* case evidence, even if relevant,

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[4]Respondents' remaining arguments on this issue are without merit. They conflate the abuse-of-discretion standard of review that applies to an order granting or denying a motion for a new trial with the appellate remedy of a new trial for harmful error. *See* NRCP 61 (addressing correction of errors that affect the party's substantial rights at all stages of the proceeding). Although they point out that there is no "order to review," appellants did not file a motion for a new trial, and thus, this court is not tasked with determining whether the district court abused its discretion by denying a motion for a new trial. Instead, appellants seek our review in evaluating whether the district court erred by admitting or excluding several pieces of evidence and whether those errors, preserved by timely objections, are harmful. Similarly, respondents' argument that appellants seek to "convert this Court into a factfinder" is misplaced, as this court is merely conducting routine error analysis of several evidentiary rulings.

is inadmissible because the danger of unfair prejudice, confusing the issues, or misleading the jury substantially outweighs its probative value. We agree.

Generally, relevant evidence is admissible, while irrelevant evidence is not admissible. NRS 48.025. Evidence is relevant if it "ha[s] any tendency to make the existence of any fact . . . of consequence . . . more or less probable than it would be without the evidence." NRS 48.015. However, relevant "evidence is not admissible if its probative value is substantially outweighed by the danger of unfair prejudice, of confusion of the issues or of misleading the jury." NRS 48.035(1). While evidence of a doctor's other acts is inadmissible to show propensity, such evidence "may . . . be admissible for other purposes," such as to show "absence of mistake or accident." NRS 48.045(2).

Reviewing for an abuse of discretion, *Hansen v. Universal Health Servs. of Nev., Inc.*, 115 Nev. 24, 27, 974 P.2d 1158, 1160 (1999), we conclude that respondents did not present evidence regarding the *Center* case for an admissible, relevant purpose, and thus it should have been excluded. While respondents argue that the case is relevant to establish that Rives's actions would cause foreseeable harm, the fact that Rives was sued or acted inconsistently with the standard of care in a prior case does not make it more or less probable that he acted below the standard of care in *this* case. *See Stottlemyer v. Ghramm*, 597 S.E.2d 191, 194 (Va. 2004) (affirming district court's exclusion of evidence of the doctor-defendant's past medical malpractice suits because "[e]vidence that a defendant was negligent on a prior occasion simply has no relevance or bearing upon whether the defendant was negligent during the occasion that is the subject of the litigation"); *cf. Mitchell v. Eighth Judicial Dist. Court*, 131 Nev. 163,

174-75, 359 P.3d 1096, 1103-04 (2015) ("Of legal consequence to a medical malpractice claim is whether the practitioner's conduct fell below the standard of care, not why. Put another way, [plaintiff] wins if she shows that [the practitioner's] misadministration of the anesthetic fell below the standard of care and caused [the victim's] injuries; legally, [the practitioner's] diminished capacity doesn't matter." (emphases and citation omitted)). Thus, the alleged foreseeability of the harm is not relevant in this kind of case, aside from the establishment of the standard of care through experts. *See Rees v. Roderiques*, 101 Nev. 302, 304, 701 P.2d 1017, 1019 (1985) ("The standard of care to be applied in a medical malpractice case is to be established by the testimony of expert witnesses with knowledge of the prevailing standards.").

Even if the *Center* case evidence had been offered for an admissible purpose, we conclude the district court abused its discretion in admitting the evidence and allowing it to be presented so extensively because the danger of unfair prejudice, confusing the issues, or misleading the jury substantially outweighed the probative value of that evidence. The *Center* case is somewhat factually similar to this case, but it arises from a different surgery on a different patient on a different day with different consequences. Introduction of such evidence injects a collateral matter into appellants' trial that would likely confuse the jury. *See Hansen*, 115 Nev. at 27-28, 974 P.2d at 1160 (affirming a district court's exclusion of a report containing brief descriptions of medical complications experienced by the doctor-defendant's patients who underwent the same surgery as the plaintiff because "injecting these other cases into [the plaintiff's] trial would prolong the trial, confuse the issues and divert the jury from [the plaintiff's] case to collateral matters"); *see also Kunnanz v. Edge*, 515 N.W.2d 167, 171

(N.D. 1994) ("The purpose of [plaintiffs'] proffered evidence was to show that [defendant] was negligent in treating [a third party]. However, that evidence was not admissible to show that [defendant] was negligent in treating [plaintiff], and its introduction would have injected a collateral matter into this trial and confused the jury."). Further, in addressing whether appellants should be sanctioned for intentional concealment of the *Center* case, respondents acknowledged that they thought the case was useful to show propensity when they stated that appellants "didn't want us to know what [Rives] knew, what his knowledge level was. [Appellants] didn't want us to know that he had gone through this exact same thing, had the same opportunity to make good decisions and protect this patient but failed to do so." Nevada law precludes admitting evidence for propensity purposes.[5] NRS 48.045(2) (prohibiting use of other wrongs or acts to prove a person's character or to show the person acted in conformity therewith); *Bongiovi v Sullivan*, 122 Nev. 556, 574, 138 P.3d 433, 447 (2006) (holding that prior bad-acts evidence is inadmissible to prove propensity); *see also Bair v. Callahan*, 664 F.3d 1225, 1229 (8th Cir. 2012) (concluding that evidence of prior malpractice is inadmissible under Federal Rule of Evidence (FRE) 404, which prohibits evidence of a person's character to prove that on a particular occasion the person acted in accordance therewith, because it allows the jury to infer the doctor has a propensity for

[5]This opinion does not concern the exception to this rule in NRS 48.045(3), which "permits the district court to admit evidence of a separate sexual offense for purposes of proving propensity in a sexual offense prosecution" so long as that evidence is relevant, proven by a preponderance of the evidence, and the danger of unfair prejudice does not substantially outweigh the probative value of the evidence. *Franks v. State*, 135 Nev. 1, 2, 432 P.3d 752, 754 (2019).

negligence); *Lai v. Sagle*, 818 A.2d 237, 247 (Md. 2003) ("[S]imilar acts of prior malpractice litigation should be excluded to prevent a jury from concluding that a doctor has a propensity to commit medical malpractice.").

Respondents' arguments to the contrary are unpersuasive. First, they argue "that bias is a relevant inquiry into the *Center* case" but fail to explain—here or below—how a prior medical malpractice case shows that the doctor-defendant is biased. Thus, we need not consider this argument. *See Edwards v. Emperor's Garden Rest.*, 122 Nev. 317, 330 n.38, 130 P.3d 1280, 1288 n.38 (2006) (explaining that this court will not consider claims unsupported by cogent argument and relevant authority). Second, they argue that the *Center* case is admissible under NRS 48.045(2) as modus operandi evidence. However, modus operandi is a narrow exception typically applied in criminal cases when there is a question regarding the defendant's identity and a defendant has committed prior offenses in the same unique way that would establish he is the offender in the present case. *See Rosky v. State*, 121 Nev. 184, 197, 111 P.3d 690, 698 (2005) (holding that the district court abused its discretion by admitting evidence of the defendant's prior bad acts as modus operandi evidence because the defendant's identity was not at issue during the trial). Here, it appears respondents argue that the modus operandi exception applies to show Rives's negligent surgical techniques, which is an inadmissible propensity use of the evidence, as it encourages the jury to infer from Rives's prior act that Rives has a propensity to commit medical malpractice; clearly, there was no question about Rives's identity here.[6]

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[6]At oral argument before this court, respondents asserted that the evidence of the *Center* case was admissible for impeachment purposes. But we need not consider this argument, as it was raised for the first time at

Further, respondents' arguments to the contrary notwithstanding, the *Center* case evidence is not admissible to show knowledge. The knowledge exception is typically applied to refute, among other things, a defendant's claim that he was unaware of the illegality of his conduct, not that he was aware his professional actions were negligent on an earlier occasion, and thus, he knew he could potentially injure another party in rendering similar professional services. *See, e.g., Fields v. State*, 125 Nev. 785, 792, 220 P.3d 709, 714 (2009) (explaining that a defendant's "knowing participation in prior bad acts with" coconspirators may be used to refute the defendant's claim that he was an unwitting or innocent bystander to the crime); *Cirillo v. State*, 96 Nev. 489, 492, 611 P.2d 1093, 1095 (1980) (concluding that "evidence of previous instances of [drug] possession may be used to show the defendant's knowledge of the controlled nature of a substance, when such knowledge is an element of the offense charged"); *see also United States v. Vo*, 413 F.3d 1010, 1019 (9th Cir. 2005) (concluding that the defendant's prior conviction for drug trafficking was admissible under FRE 404(b) because it "was evidence of his knowledge of drug trafficking and distribution in general" and "tended to show that [the defendant] was familiar with distribution of illegal drugs and that his actions in this case were not an accident or a mistake"). Moreover, other jurisdictions that addressed this issue have concluded that prior medical

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oral argument. *See State ex rel. Dep't of Highways v. Pinson*, 65 Nev. 510, 530, 199 P.2d 631, 641 (1948) ("The parties, in oral arguments, are confined to issues or matters properly before the court, and we can consider nothing else . . . ."). Even if we consider this argument, however, the numerous times respondents mentioned the *Center* case and the scope of what was mentioned far exceeded what would have been permissible for impeachment purposes.

malpractice suits do not fall within the knowledge exception, and we find their reasoning persuasive. *See, e.g., Bair*, 664 F.3d at 1229 (rejecting the appellant's argument that the doctor's past treatment of other patients is admissible to show the doctor did not know how to properly carry out the surgery because that "is not the kind of 'knowledge' Rule 404(b) contemplates," as the doctor "had the knowledge to perform the surgery" due to his training and the appellant's evidence allows the jury to infer the defendant "had a propensity to commit malpractice" (internal quotation marks omitted)).

Because the *Center* case was mentioned over 180 times during trial, including details of how the patient went septic and her legs were amputated, similar to—but worse than—the injuries suffered by Farris, the error in admitting it was not harmless. Rather, the evidence had no probative value, drew the jury's attention to a collateral matter, and likely led to the jury drawing improper conclusions about Rives's propensity to commit malpractice, unfairly prejudicing him.[7] *See Bongiovi*, 122 Nev. at

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[7]While the district court may have correctly determined that Rives's discovery behavior warranted sanctions, it nonetheless abused its discretion by giving an adverse-inference instruction. *See Bass-Davis v. Davis*, 122 Nev. 442, 447-48, 134 P.3d 103, 106 (2006) (reviewing a district court's decision to give an adverse-inference instruction for an abuse of discretion). As discussed above, the *Center* case evidence was inadmissible, and a district court may not admit otherwise inadmissible evidence as a discovery sanction. *See* NRS 48.025(2) ("Evidence which is not relevant is not admissible."); NRS 48.035(1) (providing that otherwise relevant evidence is not admissible if the danger of unfair prejudice substantially outweighs the evidence's probative value). Further, an adverse inference instruction is appropriate when evidence is lost or destroyed. *See Bass-Davis*, 122 Nev. at 448-49, 134 P.3d at 106-07. Here, the evidence was not lost or destroyed, and Farris presented details regarding the *Center* case at trial. Accordingly, the adverse inference instruction was improper.

575, 138 P.3d at 447 (explaining that evidence is inadmissible if the danger of unfair prejudice substantially outweighs the evidence's probative value). Thus, we reverse the district court's judgment and remand for a new trial.[8] *See Khoury v. Seastrand*, 132 Nev. 520, 539, 377 P.3d 81, 94 (2016) (concluding that an error is prejudicial, and thus reversible, when it affects the party's substantial rights).

CONCLUSION

An appellant who made an evidentiary objection during trial need not move for a new trial in the district court before filing an appeal to preserve the appellate remedy of reversal and remand for a new trial. Further, an appellate court has jurisdiction to review a district court's oral evidentiary rulings made during the course of trial on appeal from a final judgment. Additionally, evidence of a doctor's prior medical malpractice suits is generally not relevant to whether the doctor met the standard of care in the current malpractice lawsuit. On this record, we conclude the district court abused its discretion by admitting evidence of the *Center* case and that the error was not harmless due to the evidence's tendency to encourage the jury to reach an improper propensity conclusion, as well as to cause unfair prejudice to Rives due to the severe injuries suffered by that

[8]In light of our conclusion, we need not address appellants' remaining arguments. Similarly, we vacate the district court's order awarding attorney fees and costs. As we are remanding for a new trial, the cross-appeal regarding the district court's reduction of the noneconomic damages awarded is similarly moot.

patient. Accordingly, we reverse the district court's judgment, vacate the corresponding fees and costs order, and remand for a new trial.

_____, J.
Cadish

We concur:

_____ C.J.
Parraguirre

_____, J.
Hardesty

_____, J.
Stiglich

_____, J.
Silver

_____, J.
Pickering

_____, J.
Herndon

EXHIBIT 6

EXHIBIT 6

RMJUD

D. Lee Roberts, Jr., Esq.
Nevada Bar No. 8877
lroberts@wwhgd.com
Colby L. Balkenbush, Esq.
Nevada Bar No. 13066
cbalkenbush@wwhgd.com
Brittany M. Llewellyn, Esq.
Nevada Bar No. 13527
bllewellyn@wwhgd.com
Phillip N. Smith, Jr., Esq.
Nevada Bar No. 10233
psmithjr@wwhgd.com
Marjan Hajimirzaee, Esq.
Nevada Bar No. 11984
mhajimirzaee@wwhgd.com
WEINBERG, WHEELER, HUDGINS, GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
Telephone: (702) 938-3838
Facsimile: (702) 938-3864

Daniel F. Polsenberg, Esq.
Nevada Bar No. 2376
dpolsenberg@lewisroca.com
Joel D. Henriod, Esq.
Nevada Bar No. 8492
jhenriod@lewisroca.com
Abraham G. Smith, Esq.
Nevada Bar No. 13250
asmith@lewisroca.com
Lewis Roca Rothgerber Christie LLP
3993 Howard Hughes Parkway, Suite 600
Las Vegas, Nevada 89169-5996
Telephone: (702) 949-8200

Dimitri D. Portnoi, Esq.(*Admitted Pro Hac Vice*)
dportnoi@omm.com
Jason A. Orr, Esq. (*Admitted Pro Hac Vice)*
jorr@omm.com
Adam G. Levine, Esq. *(Admitted Pro Hac Vice)*
alevine@omm.com
Hannah Dunham, Esq. *(Admitted Pro Hac Vice)*
hdunham@omm.com
Nadia L. Farjood, Esq. (*Admitted Pro Hac Vice*)
nfarjood@omm.com
O'Melveny & Myers LLP
400 S. Hope St., 18th Floor
Los Angeles, CA 90071
Telephone: (213) 430-6000

K. Lee Blalack, II, Esq.(*Admitted Pro Hac Vice)*
lblalack@omm.com
Jeffrey E. Gordon, Esq. *(Admitted Pro Hac Vice)*
jgordon@omm.com
Kevin D. Feder, Esq. *(Admitted Pro Hac Vice)*
kfeder@omm.com
Jason Yan, Esq. *(Admitted Pro Hac Vice)*
jyan@omm.com
O'Melveny & Myers LLP
1625 Eye St., N.W.
Washington, D.C. 20006
Telephone: (202) 383-5374

Paul J. Wooten, Esq. *(Admitted Pro Hac Vice)*
pwooten@omm.com
Philip E. Legendy *(Admitted Pro Hac Vice)*
plegendy@omm.com
O'Melveny & Myers LLP
Times Square Tower, Seven Times Square
New York, NY 10036
Telephone: (212) 728-5857

Attorneys for Defendants

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation,

Plaintiffs,

Case No.: A-19-792978-B
Dept. No.: 27

HEARING REQUESTED

DEFENDANTS' RENEWED MOTION FOR JUDGMENT AS A MATTER OF LAW

vs.

UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20,

Defendants.

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I. INTRODUCTION

Defendants United Healthcare Insurance Company ("UHIC"), United Health Care Services Inc. ("UHS", which does business as UnitedHealthcare or "UHC" and through UHIC), UMR, Inc. ("UMR"), Sierra Health and Life Insurance Company ("SHL"), and Health Plan of Nevada, Inc. ("HPN") (collectively, "Defendants"), bring this Renewed Motion for Judgment as a Matter of Law ("Motion").

TeamHealth Plaintiffs[1] did not present any relevant evidence related to several of the Defendants, and no evidence related to key elements of nearly every cause of action in their Second Amended Complaint ("SAC"). The jury's verdict also forecloses TeamHealth Plaintiffs' unjust enrichment claims. This Court should direct a verdict on all of TeamHealth Plaintiffs' claims, which fail as a matter of law:

- TeamHealth Plaintiffs presented no evidence on the conduct of SHL, HPN, or UMR. Without such proof, all claims against these Defendants fail as a matter of law.
- All Defendants are entitled to judgment as a matter of law on TeamHealth Plaintiffs' claim under the Unfair Claims Practices Act. Because they are not insureds, TeamHealth Plaintiffs lack standing to bring this claim against Defendants. And two Defendants (UHS and UMR) are not insurers at all, so this statute does not apply to them. In addition, TeamHealth Plaintiffs failed to present evidence on key elements of this cause of action: (1) whether Defendants' liability was "reasonably clear"; (2) whether Defendants failed to effectuate a prompt, equitable, and fair settlement; (3) whether officers or directors knowingly permitted the violations; and (4) whether TeamHealth Plaintiffs were actually harmed by Defendants' claims process.

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[1] The "TeamHealth Plaintiffs" collectively refers to the three Plaintiffs that initiated this action, each of which is owned by and affiliated with TeamHealth Holdings, Inc.: Fremont Emergency Services (Mandavia), Ltd. ("Fremont"), Team Physicians of Nevada-Mandavia, P.C. ("TPN"), and Crum, Stefanko and Jones, Ltd., d/b/a Ruby Crest Emergency Medicine ("Ruby Crest").

- TeamHealth Plaintiffs have not presented any evidence that could support punitive damages. The only cause of action for which TeamHealth Plaintiffs appropriately sought punitive damages is their claim under the Unfair Claims Practices Act.[2] Because only insurers can be liable under that Act, punitive damages cannot be awarded against non-insurer Defendants UHS and UMR. Punitive damages also cannot be awarded against any Defendant because TeamHealth Plaintiffs' claim under the Act sounds in contract, not tort. And even if punitive damages could be awarded on this claim, TeamHealth Plaintiffs have presented no evidence that Defendants acted with malice, fraud, or oppression.
- To the extent the Court disagrees that Defendants are entitled to judgment as a matter of law on TeamHealth Plaintiffs' cause of action for breach of implied-in-fact contract, Defendants must necessarily be entitled to judgment as a matter of law on TeamHealth Plaintiffs' unjust enrichment claims. That is, because these claims are mutually exclusive, unjust enrichment claims cannot stand when a valid contract exists.
- All Defendants are entitled to judgment as a matter of law on TeamHealth Plaintiffs' cause of action for breach of an implied-in-fact contract because TeamHealth Plaintiffs failed to present any evidence the jury could consider on basic questions of contract formation: (1) whether the parties intended to contract, (2) whether promises were exchanged, and (3) whether the terms of the contract were reasonably clear.
- All Defendants are entitled to judgment as a matter of law on TeamHealth Plaintiffs' Prompt Pay Act claim. Only insureds have standing to bring a suit under that Act, and TeamHealth Plaintiffs are not the Defendants' insureds. In addition,

[2] Even assuming that TeamHealth Plaintiffs properly asserted that they were seeking punitive damages when they raised this position for the first time halfway through trial, a position inconsistent with both the SAC and the Joint Pretrial Memorandum ("JPTO"), TeamHealth Plaintiffs are not entitled to punitive damages based on these claims because TeamHealth Plaintiffs' unjust enrichment claims fail as a matter of law.

TeamHealth Plaintiffs failed to exhaust available administrative remedies under the Insurance Code, rendering their claims nonjusticiable as a matter of Nevada law. Finally, the jury found that TeamHealth Plaintiffs were not entitled to their full billed charges, which necessarily means the At-Issue claims were not "fully payable" as required under the Act.

- All of TeamHealth Plaintiffs' causes of action are subject to conflict preemption under ERISA § 514, and Defendants are therefore entitled to judgment as a matter of law on every cause of action.

For the reasons discussed in this Motion, this Court should grant Defendants judgment as a matter of law.

II. LEGAL ARGUMENT

"If the court does not grant a motion for judgment as a matter of law made under Rule 50(a),[3] the court is considered to have submitted the action to the jury subject to the court's later deciding the legal questions raised by the motion." NRCP 50(b). "No later than 28 days after service of written notice of entry of judgment . . . the movant may file a renewed motion for judgment as a matter of law and may include an alternative or joint request for a new trial under Rule 59." *Id.* "In ruling on the renewed motion, the court may: (1) allow judgment on the verdict, if the jury returned a verdict; (2) order a new trial; or (3) direct the entry of judgment as a matter of law." *Id.* To bring a renewed motion for judgment as a matter of law under Rule 50(b), the moving party must have made a companion Rule 50(a) motion earlier in the trial. NRCP 50(b). *See, e.g.*, *Zhang v. Barnes*, 132 Nev. 1049, 382 P.3d 878 (2016); *City of Reno v. Bedian*, 131 Nev. 1264 (Nev. App. 2015). "The standards for granting a motion for judgment notwithstanding the verdict are the same as those for granting a directed verdict." *Sheeketski v. Bartoli*, 86 Nev. 704, 475 P.2d 675, 706 (1970).

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[3] Defendants moved twice for judgment as a matter of law under Rule 50(a) during trial: in writing on November 17, 2021 after TeamHealth Plaintiffs' rested, and orally on December 6, 2021, after the jury returned its verdict on liability, but before the punitive damages phase. *See* Defs. Mot. for Judgment as a Matter of Law; 12/6/2021 Tr. 50:17-56:18.

This Court may enter judgment as a matter of law "when 'the evidence is so overwhelming for one party that any other verdict would be contrary to the law.'" *Grosjean v. Imperial Palace, Inc.*, 125 Nev. 349, 362, 212 P.3d 1068, 1077 (2009) (quoting *M.C. Multi-Family Dev., L.L.C. v. Crestdale Assocs., Ltd.*, 124 Nev. 901, 910, 193 P.3d 536, 542 (2008)). Such a determination requires the establishment of clear, uncontradicted, self-consistent, and unimpeached evidence. *Sheeketski*, 475 P.2d at 677. In considering a motion for judgment as a matter of law, the court must view the evidence and all inferences from the evidence in a light most favorable to the party against whom the motion is directed; it must not weigh the evidence or evaluate the credibility of the witnesses. *State Univ. & Cmty. Coll. Sys. v. Sutton*, 120 Nev. 972, 986, 103 P.3d 8, 18 (2004); *Banks v. Sunrise Hosp.*, 120 Nev. 822, 839, 102 P.3d 52, 64 (2004); *Connell*, 97 Nev. at 438, 634 P.2d at 674. "[A] nonmoving party can defeat a motion for judgment as a matter of law if it presents sufficient evidence such that the jury could grant relief to that party." *D&D Tire v. Ouellette*, 131 Nev. 462, 466, 353 P.3d 32, 35 (2015).

Defendants are entitled to judgment as a matter of law on all of TeamHealth Plaintiffs' remaining claims.[4] Judgment should be entered in favor of SHL, HPN, and UMR for all claims, for the simple reason that TeamHealth Plaintiffs failed to present any evidence related to these Defendants on key elements of their causes of action. All Defendants are entitled to judgment as a matter of law on TeamHealth Plaintiffs' claim under the Unfair Claims Practices Act; not only because TeamHealth Plaintiffs lack standing under that Act, but also because they have presented no evidence on key elements of that claim. Because TeamHealth Plaintiffs properly sought punitive damages only under that cause of action, their claim for punitive damages must also fail. Every Defendant is entitled to judgment as a matter of law on TeamHealth Plaintiffs' claim for breach of implied-in-fact contract because TeamHealth Plaintiffs presented no evidence showing the basic elements of contract formation. To the extent the Court disagrees that Defendants are entitled to judgment as a matter of law on TeamHealth Plaintiffs' implied-in-fact contract claims,

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[4] In fact, because all of TeamHealth Plaintiffs' causes of action are preempted by ERISA, *see infra* Section F, Defendants are entitled to judgment as a matter of law on all claims.

all Defendants are entitled to judgment as a matter of law on TeamHealth Plaintiffs' unjust enrichment claims because the jury found that there was an implied-in-fact contract between TeamHealth Plaintiffs and Defendants. And even if TeamHealth Plaintiffs properly sought punitive damages under their unjust enrichment claims (they did not), because those claims must be dismissed as a matter of law, TeamHealth Plaintiffs' punitive damages claims fail under this theory, as well. Every Defendant is also entitled to judgment on TeamHealth Plaintiffs' claim under the Prompt Pay Act, because TeamHealth Plaintiffs do not have a private right of action under that Act, because they failed to exhaust available administrative remedies, and because the jury found that TeamHealth Plaintiffs were entitled to only a portion of their full billed charges.

A. There Is No Evidence to Support Any of TeamHealth Plaintiffs' Claims Against SHL, HPN, or UMR

At the heart of TeamHealth Plaintiffs' case is their contentions regarding certain of UnitedHealthcare's (e.g., Defendants UHS and UHIC's) out-of-network programs—particularly, the development and implementation of the outlier cost management program. And yet, TeamHealth Plaintiffs introduced ***no evidence*** to establish any claim against SHL, HPN, or UMR, all of whom reimburse ***independently*** of the UnitedHealthcare out-of-network programs at issue in this case. No testimony came in regarding the history of any relationship or amount of pre-disputed claim reimbursements between SHL, HPN, or UMR on the one hand, and any of the TeamHealth Plaintiffs on the other. There is no evidence about any interactions or course of dealing between TeamHealth Plaintiffs and SHL, HPN, or UMR. While TeamHealth Plaintiffs did present some evidence concerning SHL, HPN, and UMR's different out-of-network reimbursement methodologies or programs, that evidence did not support their "one size fits all" approach to trying this case against different defendants with different reimbursement methodologies. As an initial matter, SHL and HPN's claims director actually testified that these two Nevada entities ***do not*** use "cost reduction or savings programs" and ***do not*** use MultiPlan – the thirty-party vendor featured prominently in TeamHealth Plaintiffs' case against UHS and UHIC. 11/16/2021 Tr. 158:14-18 (Ms. Hare testified that SHL and HPN do not use "cost reduction or savings programs"); *id.* 177:13-16 (same). And while TeamHealth Plaintiffs did establish that

UMR earns a fee for certain out-of-network programs that do not pay claims at billed charges (*see, e.g.*, 11/15/2021 Tr. 188:22–189:7 (testifying that UMR has "programs that a client can elect to offer, and one of the ways that we charge for those programs is a percentage of savings")) and that UMR uses third-party vendors including (but not limited to) MultiPlan (*see id.* 211:8–11), the testimony clearly establishes that UMR developed these programs independently of UnitedHealthcare and in fact implemented programs using Data iSight ***independent of and before*** UnitedHealthcare. *See* 11/10/2021 Tr. 142:25-143:12; DX4569. Thus, the evidence regarding UMR merely establishes that UMR had "similar" programs with similar fee structures. *Id.* 194:20–205:2 (eliciting testimony from Mr. Ziemer about claims being paid based on UMR's out-of-network programs and UMR's fees); *id.* 221:10–224:16 (questioning based on how summary plan documents administered by UMR determine At-Issue Claim reimbursement). This is plainly insufficient. Nor have TeamHealth Plaintiffs introduced a single document that evidences a contract manifested by conduct. *See, e.g.*, P159 (UMR's administrative services agreement with a client); 11/15/2021 Tr. 197:21–203:23 (questioning related to P159 and how it relates to claims reimbursement). Without specific evidence apart from the list of claims itself (which purports to show the amounts billed and amounts allowed, and little else, *see* P473), TeamHealth Plaintiffs have not proved their causes of action against these Defendants—mostly glaringly as to SHL and HPN. This complete failure of proof makes any verdict against these Defendants contrary to law.

TeamHealth Plaintiffs' causes of action require proof of something more than a disparity between their billed charges and the amounts they received in reimbursement. Without evidence of a course of dealing between TeamHealth Plaintiffs, on the one hand, and SHL, HPN, and UMR on the other, there are no facts from which jurors could infer an implied-in-fact contract. *Smith v. Recrion Corp.*, 91 Nev. 666, 668, 541 P.2d 663, 664 (1975) (terms of an implied-in-fact contract are "manifested by conduct"). Without specific evidence about the individual claims submitted to these Defendants, their liability could not be "reasonably clear" for the purposes of TeamHealth Plaintiffs' Unfair Claims Practices Act claim. NRS 686A.310(e) (unlawful for insurer to "fail[] to effectuate prompt, fair and equitable settlements of claims in which liability of the insurer has become reasonably clear"). And without evidence about these Defendants' conduct in retaining a

benefit, there cannot be sufficient proof that they were unjustly enriched by paying TeamHealth Plaintiffs what they did on the claims that were submitted to them. Judgment should be entered in favor of UMR, SHL, and HPN on all causes of action.

B. Defendants Are Entitled to Judgment as a Matter of Law on TeamHealth Plaintiffs' Cause of Action Under the Nevada Unfair Insurance Practice Act

TeamHealth Plaintiffs bring a cause of action against all Defendants under the Unfair Claims Practices Act. That Act confers standing only on an ***insured*** as against its ***insurer***. TeamHealth Plaintiffs are not insureds, and several of the Defendants are not insurers. Even if they were, TeamHealth Plaintiffs have failed to offer evidence on several of the elements of this cause of action. Defendants are entitled to judgment as a matter of law.

1. TeamHealth Plaintiffs Lack Standing to Assert a Cause of Action Under the Unfair Claims Practices Act

Under the text of the Unfair Claims Practices Act, under the many decisions of the Nevada Supreme Court and other cases, and under the guidance of the Nevada Insurance Commissioner, no private right of action exists in favor of TeamHealth Plaintiffs against any Defendant.

The text of the Unfair Claims Practices Act is conclusive on this subject. The private right of action, added by the Nevada Legislature in 1987, is created by the following language:

> In addition to any rights or remedies available to the Commissioner, ***an insurer is liable to its insured*** for any damages sustained by the insured as a result of the commission of any act set forth in subsection 1 as an unfair practice.

NRS 686A.310(2) (emphasis added); *see also* 1987 St. of Nev., Ch. 470 p. 1067 A.B. 811. The Nevada Legislature in 1989 considered language to "expressly provide for action by a third party claimant for violation of the unfair claims settlement practices act by insurance companies," but no such enactment has ever been added. *Crystal Bay Gen. Imp. Dist. v. Aetna Cas. & Sur. Co.*, 713 F. Supp. 1371, 1377 (D. Nev. 1989). There is, therefore, no text supporting a cause of action in favor of a third-party claimant against any defendant.

TeamHealth Plaintiffs, as service providers, are mere third party beneficiaries to an insurance contract, and have no right to file claims for breach under the Unfair Claims Practices

Act. The seminal case on this subject, *Tweet v. Webster*, 614 F. Supp. 1190 (D. Nev. 1985), held that the Act did not create a private cause of action. In that case, Chief Judge Reed extensively canvassed the text and history of the Act, similar enactments in California and elsewhere, the model code upon which these acts are based, and legislative history, and concluded that no private right of action existed under the Act. "Where Nevada's insurance code has *no* language relating to other liability of insurers," other than those expressly provided, "none can be read in." *Id.* at 1194. "[W]here a legislature writes an insurance code with specific penalties and remedies for violation thereof, the code is as the legislature intended." *Id.*[5]

Case after case since *Tweet* and since the 1987 enactment of a private right of action has consistently refused to find an extra-textual right of action in favor of third-party claimants or medical providers. *See, e.g., Crystal Bay*, 713 F.Supp. at 1376 (while right of action for insured, there was "no reason to disagree with [the court's] conclusion that the Act created no private right of action in favor of third party claimants against the insurer."); *Burley v. Nat'l Union Fire Ins. Co. of Pittsburgh PA*, No. 315CV00272HDMWGC, 2016 WL 4467892, at *2 (D. Nev. Aug. 22, 2016) ("It is well established that third party claimants have no private cause of action under NRS 686A.310."); *Talbot v. Sentinel Ins. Co.*, No. 2:11-CV-01766-MMD, 2012 WL 3995562, at *4 (D. Nev. Sept. 10, 2012) ("The law in Nevada is clear: third-party claimants may not bring claims against insurers or their insured under NRS § 686A.310."); *Weast v. Travelers Cas. & Sur. Co.*, 7 F. Supp. 2d 1129, 1132 (D. Nev. 1998) ("[T]he [Nevada Unfair Practices] Act created no private right of action in favor of third party claimants against the insurer."); *Hunt v. State Farm Mut. Auto. Ins. Co.*, 655 F. Supp. 284, 287 (D. Nev. 1987) ("Nevada does not recognize a right of action on the part of a third-party claimant against an insurance company for bad-faith refusal to settle.").

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[5] As noted above, the Nevada Legislature enacted a new provision of the Unfair Claims Practices Act two years after *Tweet*, that provided for a private right of action where "an insurer is liable to its insured." 1987 St. of Nev., Ch. 470 p. 1067 A.B. 811. As also noted, the Nevada Legislature considered and rejected a private right of action in favor of third-party claimants like TeamHealth Plaintiffs. *Crystal Bay*, 713 F. Supp. at 1377.

The Nevada Supreme Court has also held that that individuals in far closer privity than TeamHealth Plaintiffs to the underlying insurance contract lacked standing to sue. *See United First Ins. Co. v. McClelland*, 105 Nev. 504, 780 P.2d 193 (1989) (where dependent of person whose benefits were denied sued, dependent not considered insured under policy for purposes of standing); *Gunny v. Allstate Insurance Co.*, 108 Nev. 344, 346, 830 P.2d 1335, 1336 (1992) (where son injured in boat operated by father, son did not have standing to sue under NRS 686A.310 for claim under father's insurance policy).

Cases since *Gunny* have consistently applied its holding to permit only an insured with an insurance contract with the insurer to pursue claims under the Act. *See, e.g., Fulbrook v. Allstate Ins. Co.*, Nos. 61567, 62199, 2015 WL 439598, at *4 (Nev. Jan. 30, 2015) ("This statute, however, does not provide a private right of action to third-party claimants."); *Wilson v. Bristol W. Ins. Grp.*, No. 209-CV-00006-KJD-GWF, 2009 WL 3105602, at *2 (D. Nev. Sept. 21, 2009) ("No private right of action as a third-party claimant is created under NRS 686A.310."). [6]

It may be, as some federal district courts have suggested, that where the insured assigns its benefits to a third-party claimant such as a medical provider, that third-party claimant may step into the shoes of insured. But that is irrelevant to this case. "Without an assignment, voluntary or forced," TeamHealth Plaintiffs "still lacked standing to proceed directly against" Defendants for liability under the Act.[7] *Bell v. Am. Fam. Mut. Ins. Co.*, 127 Nev. 1118, 373 P.3d 895 (2011); *see*

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[6] In *Bergerud v. Progressive Casualty Insurance*, 453 F. Supp. 2d 1241 (2006), the court permitted a claim under the Act to survive a motion to dismiss where the plaintiff "is an insured, had a contractual relationship with [the insurer-defendant], and is a first-party claimant." *Id.* at 1250. The court also noted in *dicta* that "Nevada does not exclude non-contracting parties from asserting a private right of action for violation of the … Act. Instead, only third-party claimants and parties without a contractual relationship with an insurer cannot assert a claim under the … Act." *Id.* This *dicta*, however, was unrelated to the case and inconsistent with *Gunny*, insofar as it confuses *Gunny*'s holding on the common-law bad faith claim with the holding on the Unfair Claims Practices Act claim.

[7] Defendants have always contended—and continue to contend—that the Plaintiffs in fact received assignments of benefits from all of Defendants' plan members and by virtue of those assignments, stand in the shoes of Defendants' plan members which must result in all of Plaintiffs' claims being subject to preemption under ERISA. However, Plaintiffs have disclaimed any reliance on these assignments and the Court has repeatedly rejected Defendants' argument. Therefore, Plaintiffs are estopped from now changing course and accepting the benefit of receiving an assignment

also Hetly v. Am. Equity Ins. Co., No. 208CV00522PMPLRL, 2008 WL 11389200, at *3 (D. Nev. Nov. 14, 2008) ("However, generally, a valid assignment confers a right of standing upon the assignee to sue in place of the assignor."); *cf. Wilson*, 2009 WL 3105602, at *2 (finding no assignment of benefits to support common-law bad faith claim). For instance, in *Hicks v. Dairyland Insurance Co.*, No. 2:08-CV-1687-BES-PAL, 2009 WL 10693627 (D. Nev. Apr. 27, 2009), the Court held that a third-party claimant lacked standing under the Act where he was not an insured and lacked an assignment of benefits from the insured. *Id.* at *3. TeamHealth Plaintiffs have not only not proven such an assignment, they have disclaimed reliance on such an assignment. SAC at 2 n.5.[8]

Although TeamHealth Plaintiffs seek relief only under 686A.310(1)(e), *see* SAC ¶ 92–93; JPTO at 5 (citing SAC ¶¶ 90–97), other prongs under the heading of NRS 686A.310 refer to practices directed generally at "claimants." But TeamHealth Plaintiffs are not "claimants." The implementing regulations for the Unfair Claims Practices Act contemplate only two valid categories of claimants. A first-party claimant is defined as one "asserting a right to payment under an insurance contract or policy arising out of the occurrence of the contingency or loss covered by the contract or policy." Nev. Admin. Code 686A.625. A first-party claimant "does not include a person who provides service to an injured party." *Id.* A third-party claimant is "one asserting a claim against any person, corporation, association, partnership or other legal entity insured under an insurance contract or policy." *Id.* 686A.650. Likewise, a third-party claimant "does not include a person who provides service to an injured party." *Id.*[9] TeamHealth Plaintiffs

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(potential standing as a third party claimant) while avoiding the consequences of such an assignment (ERISA preemption).

[8] If Plaintiffs chose to rely on assignments to manufacture standing for their Unfair Insurance Practice Act claim, then the claim would be preempted by ERISA. *See DB Healthcare, LLC v. Blue Cross Blue Shield of Ariz., Inc.*, 852 F.3d 868, 873 (9th Cir. 2017) (valid assignment of benefits confers standing to bring claim under ERISA); *Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004) ("[I]f an individual, at some point in time, could have brought his claim under ERISA § 502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant's actions, then the individual's cause of action is completely pre-empted by ERISA § 502(a)(1)(B).").

[9] The only contract contemplated by these definitions would be the "insurance policy or contract" which is defined as an "insurance policy, plan or written agreement for or affecting insurance by

do not qualify as first-party or third-party claimants under the Act. Indeed, TeamHealth Plaintiffs are categorically and specifically excepted from the definition of claimant.

In short, the consistent law, as developed by the Nevada Legislature, the Nevada Supreme Court, the Nevada federal district courts, and the Nevada Commission of Insurance excludes service providers such as TeamHealth Plaintiffs from having a private right of action under the Act. This Court should follow the copious and undisputed authority- and grant Defendants judgment as a matter of law.

2. Several Defendants Are Not Insurers and Cannot Be Held Liable Under the Unfair Claims Practices Act

Notwithstanding TeamHealth Plaintiffs' unequivocal lack of standing to pursue a claim under the Unfair Claims Practice Act, the plain text of the Unfair Claims Practices Act, the consistent and unanimous case law, and the implementing regulations apply the Act to insurers only. The text provides only that "an insurer is liable to its insured." NRS 686A.310(2). The title of NRS 686A.310 makes clear that it provides for the ***liability of [an] insurer*** for damages" (emphasis added). Nevada law defines an "insurer" as "every person engaged as principal and as indemnitor, surety or contractor in the business of entering into contracts of insurance." NRS 679A.100. The Nevada Supreme Court in *Albert H. Wohlers & Co. v. Bartgis* held that a plan administrator is ***not*** an insurer for the purposes of NRS 686A.310 because they are not in the business of entering into insurance contracts. 114 Nev. 1249, 1264, 969 P.2d 949, 960 (1998).

Claims under the Unfair Claims Practices Act against UHS and UMR fail because those two Defendants are not insurers as to all claims, and UHIC is not an insurer with respect to some claims. 11/2/2021 Tr. 164:21–25 (Mr. Haben testified that some Defendants perform third party administrator services for ASO clients); 11/3/2021 Tr. 86:19–87:2 (Mr. Haben testified that defendants performing third-party administrator services pay claims based on the directives of the

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whatever name called and includes all clauses, riders or endorsements offered by any person or entity engaged in the business of insurance in this State." Nev. Admin. Code 686A.627. This definition cannot encompass the unwritten implied-in-fact contract the jury found existed in this case.

self-insured client because defendants only "administer the funds"); 11/8/2021 Tr. 152:23–153:1 (Mr. Haben testified that UMR is a third-party administrator); 11/9/2021 Tr. 130:19–131:10 (Mr. Haben testified that "UMR is the third-party administrator" and "UnitedHealthcare itself is a third-party administrator . . . [f]or self-employed groups"); 11/10/2021 Tr. 21:11–22 (Mr. Haben testified that third-party administrators "do[] not incur the medical cost risk"); *id.* 24:10–17 (Mr. Haben testified that UHIC is a third-party administrator and an insurer); *id*. 29:16–19 (Mr. Haben testified that an administrative services agreement is between "the employer group, with the third-party administrator to perform services on their behalf"); *id*. 29:20–30:10 (Mr. Haben testified that certificates of coverage are only associated with fully insured plans and summary plan documents and administrative services agreements are associated with a self-insured plan); 11/15/2021 Tr. 183:19-23 (Mr. Ziemer testified that UMR "is a third-party administrator, so what that means is that our clients are employer groups, and they wish to self-fund their benefit plan."); *id.* 184:21-185:4 (Mr. Ziemer testified that UMR is a third-party administrator and that "the employer is actually the one that pays the claims. . . . So what UMR does is we administer the benefits [] that that employer group provides to us."). These Defendants act as plan administrators for employer self-funded plans. As an administrator of an employer self-funded plans, UHS and UMR are not insurers. The employers are insurers and UHS, UMR, and UHIC provide administration services. In *Albert H. Wohlers*, an insured argued that the plan administrator was liable because an administrator fits within the statutory definition of a "person," but the Nevada Supreme Court held that "when considering unfair claims practices" the Act "proscribes unfair practices in settling claims by an insurer, which [a plan administrator] is not." 114 Nev. at 1265.

Because UHS and UMR are plan administrators and not insurers with respect to all the At-Issue Claims, the Court should direct a verdict in favor of UHS and UMR with respect to all claims under the Unfair Claims Practices Act. Because UHIC is a plan administrator with respect to 119 At-Issue Claims, the Court should direct a verdict in favor of UHIC with respect to those claims. In total, Defendants are entitled to a judgment as a matter of law on TeamHealth Plaintiffs' cause of action under the Unfair Claims Practices Act with respect to 4,636 of the At-Issue Claims because they were submitted to self-funded plans.

3. TeamHealth Plaintiffs Have Presented No Evidence That Any Defendant's Liability Was "Reasonably Clear" Prior to Trial

The Unfair Claims Practices Act delineates and proscribes many unfair practices, but TeamHealth Plaintiffs' complaint and Joint Pretrial Memorandum restrict their claim to the practice described in NRS 686A.310(1)(e): "Failing to effectuate prompt, fair and equitable settlements of claims in which liability of the insurer has become reasonably clear." *See* SAC ¶ 92; JPTO at 5 (citing SAC ¶¶ 90–97). "This statute concerns the manner in which an insurer handles an ***insured's*** claim." *Patel v. Am. Nat'l Prop. & Cas. Co.*, 367 F. Supp. 3d 1186, 1193 (D. Nev. 2019) (emphasis added).

To prevail on this claim, TeamHealth Plaintiffs must prove that Defendants failed to fairly settle payment of an insurance claim after the Defendants' liability was reasonably clear. *Yusko v. Horace Mann Servs. Corp.*, No. 2:11–cv–00278–RLH–GWF, 2012 WL 458471, at *4 (D. Nev. Feb. 10, 2012) (granting summary judgment where plaintiff had not presented any evidence that an officer, director, or department head was aware of the conduct in question); *Tweet*, 614 F. Supp. at 1194 ("Furthermore, in the present case, plaintiffs do not present probative evidence supporting their allegation that their claim against CSAA had become 'reasonably clear.'").

Here, there is no probative evidence that Defendants' liability for the At-Issue Claims had become "reasonably clear" prior to trial. In most cases, the "reasonably clear" requirement is established by the fact the insurer had concluded internally that a particular claim should be paid but did not pay the claim. But the evidence at trial ***confirmed*** that Defendants in fact paid each of the At-Issue Claims. *See* 11/16/2021 Tr. 226:23-227:10 (Mr. Leathers testified that Defendants' data for the At-Issue Claims includes reimbursement amounts); *id.* 233:12-22 (Mr. Leathers testified that he analyzed claims that were allegedly underpaid as opposed to not paid). Defendants paid those claims based on methodologies designed to arrive at a reasonable reimbursement amount. And while the record is clear that Plaintiffs would like to have received a higher reimbursement, where the specific amount owed in dispute as to any one claim is not reasonably clear to the insurer, that is sufficient to defeat this claim. *See, e.g., Clifford v. Geico Cas. Co.*, 428 F. Supp. 3d 317, 325 (D. Nev. 2019). In general, this claim is satisfied where the insurer waited

an "inordinate amount of time" to provide information about a particular claim. *See, e.g.*, *Fries v. State Farm Mut. Auto. Ins. Co.*, No. 3:08CV00559LRH-VPC, 2010 WL 653757, at *4 (D. Nev. Feb. 22, 2010); *Turk v. TIG Ins. Co.*, 616 F. Supp. 2d 1044, 1052 (D. Nev. 2009). But there is no evidence that any Defendant waited an inordinate amount of time before communicating about a claim. In fact, there is no evidence in the record about *any* Defendant's handling of *any* particular one of the At-Issue Claims.

Liability never became reasonably clear until the jury returned its verdict, which assessed liability for an amount *neither* party presented as the reasonable value of the charges. Disagreement between experts on the amounts of damages alone is enough to grant judgment to defendants because "liability has not become reasonably clear." *Lubritz v. AIG Claims, Inc.*, No. 217CV02310APGNJK, 2018 WL 7360623, at *7 (D. Nev. Dec. 18, 2018). Courts regularly hold that where there are genuine issues of material fact regarding the existence or scope of liability of an insurer, liability has perforce not become reasonably clear. *Big-D Constr. Corp. v. Take It for Granite Too*, 917 F. Supp. 2d 1096, 1118 (D. Nev. 2013).

Here, TeamHealth Plaintiffs' own expert Mr. Leathers offered two alternative theories of the amount of damages TeamHealth Plaintiffs suffered. *Compare* 11/17/2021 Tr. 16:15-16:24 (measuring damages based on full billed charges) *with id.* 286:25-287:8 (measuring damages based on average amount Defendants paid other out-of-network providers). And Defendants expert Mr. Deal offered yet another calculation. 11/18/21 Tr. 206:24-209:20 (measuring damages by comparing to out-of-network providers in same geographic region as each TeamHealth Plaintiff). And the jury's verdict further demonstrates that *no* Defendant's liability was reasonably clear because the jury *rejected* the amount TeamHealth Plaintiffs billed for each of the At-Issue claims, instead determining that a reasonable value was far less than what TeamHealth Plaintiffs requested. 11/29/21 Special Verdict Form. *See* 12/6/2022 Tr. 51:10-13. And the jury clearly disagreed with both experts, instead awarding $2.65 million in liability—an amount neither party offered as a proposed amount of damages. *Id.*

The Unfair Claims Practices Act does not prohibit good faith disagreements over the valuation of claims in the course of settling those claims. The Act targets delays in settlement

where liability, not coverage, has become reasonably clear. Because the parties' experts disagreed about the amount damages TeamHealth Plaintiffs suffered, liability never became reasonably clear until the jury rendered its verdict. And the jury's award of an amount significantly lower than TeamHealth Plaintiffs' billed charges necessarily means that there was no sum certain that was reasonably clear before trial. Based on the statutory text and the case law, liability for these At-Issue Claims is by definition not reasonably clear.

4. TeamHealth Plaintiffs Have Presented No Evidence that Defendants Failed to Effectuate a Prompt, Equitable, and Fair Settlement

TeamHealth Plaintiffs contend that Defendants failed to "effectuate a prompt, equitable, and fair settlement" because they did not negotiate with TeamHealth Plaintiffs on each of the At-Issue Claims. That is not what the Act requires. TeamHealth Plaintiffs presented no evidence that, ***where an individual claim was appealed and negotiated***, Defendants were unreasonable in negotiating a fair settlement. Indeed, they presented no evidence at trial that the parties negotiated reimbursement rates ***at all***. TeamHealth Plaintiffs offered no evidence that they communicated with Defendants and sought to negotiate a higher reimbursement on the disputed claims, and that Defendants rejected their reasonable demands for additional payment.

Without such evidence, TeamHealth Plaintiffs failed to prove that Defendants violated the Unfair Claims Practices Act as a matter of law. *See, e.g.*, *Harter v. Gov't Emps. Ins. Co.*, No. 2:19-CV-1330 JCM (EJY), 2020 WL 4586982, at *4 (D. Nev. June 11, 2020) (granting summary judgment where evidence showed defendant "negotiated in good faith"); *Matarazzo v. GEICO Cas. Co.*, No. 219CV529JCMVCF, 2020 WL 1517556, at *4 (D. Nev. Mar. 30, 2020) (granting summary judgment where insurer "promptly responded to plaintiff's requests and communications" and "had a basis for disputing plaintiff's demands for the full policy limit"); *Amini v. CSAA Gen. Ins. Co.*, No. 2:15–cv–0402–JAD–GWF, 2016 WL 6573949, at *6 (D. Nev. Nov. 4, 2016) (granting summary judgment where insurer "reasonably and promptly responded to claim communications and engaged in settlement negotiations").

5. TeamHealth Plaintiffs Have Presented No Evidence That an Officer, Director, or Department Head of Defendants Knowingly Permitted the Alleged Violations

For there to be liability under NRS 686.310, TeamHealth Plaintiffs must prove that an "officer, director, or department head of the insurer has knowingly permitted such an act or has had prior knowledge thereof." NRS 686A.270. Without evidence that an officer, director, or department head permitted the unfair insurance practices, TeamHealth Plaintiffs' claim fails as a matter of law. *Hackler v. State Farm Mut. Auto. Ins. Co.*, 210 F. Supp. 3d 1250, 1255 (D. Nev. 2016) (finding "Claims Teams Managers" did not qualify under the statutory requirements of NRS § 686A.270); *see also Yusko*, 2012 WL 458471, at *4 (granting summary judgment where plaintiff had not presented any evidence that an officer, director, or department head was aware of the conduct in question).

To be sure, TeamHealth Plaintiffs have presented testimony from officers of some of the Defendants. TeamHealth Plaintiffs questioned John Haben on the stand on five separate court days. 11/10/2021 Tr. 13:5-7 (Mr. Haben was the "Vice President of the out of network programs"). At no time did TeamHealth Plaintiffs ask Mr. Haben about his *prior* knowledge of any one of the At-Issue Claims. 11/2/2021 Tr. 123:13–128:22 (questioning based on *hypothetical* payment of $254 for treatment of a gun-shot victim); 11/9/2021 Tr. 27:18–40:12 (questioning of Mr. Haben related to one At-Issue Claim based on purported plan documents P444 (EOB), P120 (SPD), P290 (COC) elicited testimony based on documents, not prior knowledge); *id.* 40:15–45:10 (questioning related to Ruby Crest's purported appeal of the At-Issue Claim depicted in P444 (related testimony at 11/9/2021 Tr. 27:18–40:12) made clear that Mr. Haben had no knowledge of the claim appeal exhibit, P470, including Plaintiffs' counsel's assertion that Defendants would not engage with them during the appeal); *id.* 101:11–107:16 (questioning based on a MultiPlan document, P413, related to how Data iSight works made clear that Mr. Haben lacks knowledge of whether every At-Issue Claim priced by Data iSight amounted to 250–350% of Medicare); *id.* 126:16–129:20 (questioning related to the P444 At-Issue Claim and why the Data iSight pricing came out to 250% of Medicare but refusing to elicit Mr. Haben's understanding of that claim); 11/10/2021 Tr. 175:6–176:6 (questioning Mr. Haben based on *hypothetical*, but not At-Issue, claim); *id.* 176:7–181:12

(Mr. Haben read the billed charge and allowed amount from document regarding one At-Issue Claim but providing no testimony about his prior knowledge of the claim); *id.* 208:17–214:13 (Mr. Haben testified that P290 and P470 may not relate to the At-Issue Claim contained in P444). TeamHealth Plaintiffs did not elicit any testimony from Daniel Rosenthal regarding any particular At-Issue Claim. Joint Submission of Dep. Clips for Trial Record as Played on Nov. 12, 2021 10:05-06, 21:11-15 (Mr. Rosenthal testified that he was the former President of UnitedHealth Networks and the current CEO of Commercial Business for UnitedHealth Group's West Region). Rebecca Paradise, Vice President of Out-of-Network Payment Strategy, was questioned on a small number of At-Issue Claims, but she did not have prior knowledge of any of them. *See* 11/15/2021 Tr. 51:10-12; *id.* 7:22–8:4 (Ms. Paradise testified that claims in general may be paid at a higher amount than what would be remitted by MultiPlan based on direction of client); *id.* 10:4–12:12 (Ms. Paradise testified about an email regarding the experience of a United employee regarding an unknown claim priced by MultiPlan); *id.* 17:7–19:8 (questioning related to P444 that did not elicit Ms. Paradise's prior knowledge of the claim); *id.* 20:2–9 (Ms. Paradise testified that it would "untenable" for her to determine whether every claim using Data iSight was priced at 250% of Medicare); *id.* 117:5–15 (Ms. Paradise testified that she is "unaware of a specific situation" in which Defendants paid "ER claims at usual and customary"); *id.* 123:21–124:3 (Ms. Paradise testified that she does "not review[] any claim. I didn't review any of the thousands of claims that are at—at issue in this case."). Similarly, Scott Ziemer, UMR's Vice President of Customer Solutions, was questioned on a small number of claims, but he did not have any prior knowledge of them. 11/15/2021 Tr. 244:8-11; *id.* 194:20–205:2 (failing to elicit testimony from Mr. Ziemer about his prior knowledge of the specific At-Issue Claims despite showing him a demonstrative based on P473 because Plaintiffs focused on Defendants' fees); *id.* 211:8–11 (Mr. Ziemer testified that "to [his] knowledge we have not told MultiPlan or Data iSight" how to reimburse claims because "[w]e rely on their tool. They use publicly available information. They have their own algorithm to determine their reasonable amount."); *id.* 221:10–224:16 (questioning Mr. Ziemer on how a summary plan document relates to At-Issue Claims, but failing to elicit any testimony

regarding his prior knowledge of those claims); *id.* 236:11–12 ("I am not a plan document person.").

Not a single officer, director, or department head has been presented for SHL or HPN. Leslie Hare, the sole SHL and HPN witness, testified explicitly that she is not a department head. 11/16/2021 Tr. 199:11-15 (testifying that she reports to another person and does not consider herself a department head). Ms. Hare also testified that she did not have any prior knowledge regarding the At-Issue Claims. 11/16/2021 Tr. 135:6-18 (testifying that she is generally aware that the At-Issue Claims were submitted by TeamHealth Plaintiffs, but nothing else); *id.* 142:24-143:6 (failing to elicit testimony regarding the specific At-Issue Claims, but instead eliciting testimony that out-of-network claims in general get reimbursed pursuant to plan documents).

In sum, TeamHealth Plaintiffs presented no evidence that demonstrates that any officer, director, or department head permitted the unfair insurance practices that TeamHealth Plaintiffs allege.

6. TeamHealth Plaintiffs Have Presented No Evidence of Damages from Defendants' Claims Process as Opposed to the Underlying At-Issue Claims

TeamHealth Plaintiffs have no claim under the Unfair Claims Practices Act unless they prove they suffered a harm that is distinct from the underlying At-Issue Claims. *See Safety Mut. Cas. Corp. v. Clark Cty. Nev.*, No. 2:10-CV-00426-PMP, 2012 WL 1432411, at *2 (D. Nev. Apr. 25, 2012) ("Clark County does not identify any evidence raising a genuine issue of material fact that it suffered any damages from these two alleged claims handling failures apart from the denial of coverage itself."); *Sanders v. Church Mut. Ins. Co.*, No. 2:12-CV-01392-LRH, 2013 WL 663022, at *3 (D. Nev. Feb. 21, 2013) (damages under Unfair Claims Practices Act must be "costs which are separate and apart from damage caused by the underlying accident"); *Yusko*, 2012 WL 458471, at *4 ("Here, Yusko has not presented evidence of any damages resulting from Horace Mann's conduct. The only damages for which the Court has evidence are a result of the underlying accident, not the claims process or any conduct by Horace Mann."). That is, to have a valid claim under the Unfair Insurance Practice Act, TeamHealth Plaintiffs must have been separately harmed

by the ***claims process itself***, and not just through the performance of emergency medicine services that went uncompensated or undercompensated.

To the extent TeamHealth Plaintiffs presented any evidence at all that they were harmed by Defendants' conduct, that harm is limited to the plain fact that they received less than their full billed charges in Defendants' adjudication of the At-Issue Claims. They do not allege, and they have not proved, a harm that is distinct from the underpayments themselves. 11/16/2021 Tr. 65:7-10 (Leif Murphy, TeamHealth's CEO, testified that billed charges should be awarded because "[w]e perform the service"); *id.* 86:20-23 (TeamHealth "entitled to billed charge"); 11/22/2021 Tr. 75:21-76:2 (Mr. Bristow, TeamHealth Plaintiffs' corporate representative, testified that Defendants required to pay full billed charges even though they increased year over year); *id.* 85:19-22 (testimony from Mr. Bristow that "Plaintiffs' theory that they were entitled to full billed charges for the services that they billed for United members on an out-of-network basis was limited by a determination of whether those charges were or were not reasonable."). There is no evidence that TeamHealth Plaintiffs suffered "costs which are separate and apart from damage caused by the underlying accident." *Sanders*, 2013 WL 663022, at *3. For that reason, Defendants are entitled to judgment as a matter of law on TeamHealth Plaintiffs' claims under the Unfair Claims Practices Act.[10]

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[10] Consequential damages are not permitted under the Unfair Claims Practices Act, at all. *See also Van Dyke v. St. Paul Fire & Marine Ins. Co.*, 448 N.E.2d 357, 362 (Mass. 1983) (affirming summary judgment for insurer because "any omission by [the insurer] to comply with [Massachusetts' UCPA] did not cause any injury to or adversely affect the plaintiffs"); *Michelman v. Lincoln Nat. Life Ins. Co.*, 685 F.3d 887, 901 (9th Cir. 2012) (rejecting liability under Washington statute where no damages arose from the nominal statutory violation); *Provident Am. Ins. Co. v. Castaneda*, 988 S.W.2d 189, 199 (Tex. 1998) (damages under Texas statute must be "separate and apart from those that would have resulted from a wrongful denial of the claim").

But even assuming the Unfair Claims Practices Act allowed consequential damages, such damages would be available only with a showing of insurer's bad-faith intent. *U.S. Fidelity & Guar. Co. v. Peterson*, 91 Nev. 617, 619-20, 540 P.2d 1070, 1071 (1975) (adopting "the rule that allows recovery of consequential damages where there has been a showing of bad faith by the insurer"); *Blue Cross & Blue Shield of Ky., Inc. v. Whitaker*, 687 S.W.2d 557, 559 (Ky. Ct. App. 1985) ("Absent some proof that [the insurer] acted intentionally, willfully or in reckless disregard of its insured's rights, we cannot uphold a verdict allowing consequential or punitive damages."). Such a limitation is necessary to prevent parties who cannot make out a bad faith claim, as TeamHealth Plaintiffs concededly cannot here, from recovering all of the damages of such a claim without evidence of the insurer's culpable mental state.

C. There Is No Evidence That Supports an Award of Punitive Damages

Based on the evidence submitted at trial, Defendants are entitled to judgment as a matter of law on TeamHealth Plaintiffs' claim for punitive damages under the Unfair Claims Practices Act.[11] Punitive damages are available only to punish or deter "conduct that is outrageous, because of the defendant's evil motive or his reckless indifference to the rights of others." Restatement (Second) of Torts § 908(2); *see Coughlin v. Hilton Hotels Corp.*, 879 F. Supp. 1047, 1050 (D. Nev. 1995) (citing *Turnbow v. Dep't of Human Res.*, 109 Nev. 493, 853 P.2d 97, 99 (1993)) ("[P]unitive

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[11] TeamHealth Plaintiffs did not seek punitive damages in connection with any other cause of action. JPTO at 5–6; *see also* SAC ¶¶ 80–89 (no allegation of entitlement to punitive damages in Second Claim for Relief for unjust enrichment). Because in the Joint Pretrial Memorandum TeamHealth Plaintiffs did not request punitive damages in connection with the unjust enrichment cause of action, they have waived the right to seek those damages on that cause of action. "As a general proposition a pretrial order does control the subsequent course of the trial and supersedes the pleadings." *Walters v. Nev. Title Guar. Co.*, 81 Nev. 231, 234, 401 P.2d 251, 253 (1965); *see also* EDCR 2.67(b)(2) (pretrial memorandum must present "a list of all claims for relief … with each category of damage requested"). Even assuming TeamHealth Plaintiffs actually sought punitive damages on their unjust enrichment claim, because Defendants are entitled to judgment as a matter of law on TeamHealth Plaintiffs' unjust enrichment claims, TeamHealth Plaintiffs are not entitled to punitive damages on this theory, either.

Furthermore, as previously argued, unjust enrichment is a species of "quasi-contract." *Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. 371, 380–81, 283 P.3d 250, 257 (2012))and therefore not a predicate tort for punitive damages. Accordingly, Nevada trial courts consistently find that punitive damages are not available for unjust enrichment claims. *E.g.*, *Gonor v. Dale*, 2015 WL 13772882, at *2 (Dist. Ct. Nev. July 16, 2015) ("To the extent that any claims for punitive damages against the Dale defendants (i.e. unjust enrichment detrimental reliance and quantum meruit) sound in contract, not in tort, such claim for punitive damages against the Date defendants is DENIED."); *Raider v. Archon Corp.*, 2015 WL 13446907, at *2 n.1 (Dist. Ct. Nev. June 19, 2015); *Hartman v. Silver Saddle Acquisition Corp.*, 2013 WL 11274332, at *3 (Dist. Ct. Nev. Jan. 28, 2013). Other jurisdictions are also in accord. *See Priority Healthcare Corp. v. Chaudhuri*, 2008 WL 4459041 *5 (M.D. Fla. 2008) ("Because unjust enrichment is not intended to be punitive, I find that punitive damages are not available under this theory"); *Moench v. Notzon*, 2008 WL 668612 *5 n.3 (Tex. Ct. App. 2008) (noting that "exemplary damages are not available for unjust enrichment"); *U.S. East Telecommunications, Inc. v. U.S. West Information Sys., Inc.*, 1991 WL 64461 *4 (S.D.N.Y. 1991) ("Neither are punitive damages available on an unjust enrichment cause of action."); *Edible Arrangements Int'l, Inc. v. Chinsammy*, 446 F. App'x 332, 334 (2d Cir. 2011) (punitive damages not allowed because a "claim of unjust enrichment is a quasi-contract claim for which the right to recovery is 'essentially equitable.'"); *Guobadia v. Irowa*, 103 F. Supp. 3d 325, 342 (E.D.N.Y. 2015) (no punitive damages for "unjust enrichment and other quasi-contract claims"); *Seagram v. David's Towing & Recovery, Inc.*, 62 F. Supp. 3d 467, 478 (E.D. Va. 2014) (same); *Conner v. Decker*, 941 N.W.2d 355 (Iowa Ct. App. 2019) (same); *Am. Safety Ins. Serv., Inc. v. Griggs*, 959 So. 2d 322, 332 (Fla. App. 2007) ("Unjust enrichment awards are not punitive, and allowing plaintiffs a recovery worth more than the benefit conferred would result in an unwarranted windfall."); *Dewey v. Am. Stair Glide Corp.*, 557 S.W.2d 643, 650 (Mo. App. 1977) ("Dewey's theory of recovery of actual damages is based on the contract theory of unjust enrichment. It is beyond question that punitive damages do not lie for a breach of contract. Thus, Dewey is not entitled to punitive damages.").

damages are not designed to compensate the victim of a tortious act but rather to punish and deter oppressive, fraudulent or malicious conduct."); *State Farm Mut. Auto Ins. Co. v. Campbell*, 538 U.S. 408, 419 (2003) (factors that indicate outrageous conduct: "the harm caused was physical as opposed to economic; the tortious conduct evinced an indifference to or a reckless disregard of the health or safety of others; the target of the conduct had financial vulnerability; the conduct involved repeated actions or was an isolated incident; and the harm was the result of intentional malice, trickery, or deceit, or mere accident").

In analyzing whether conduct is outrageous or reprehensible in a way that permits an award of punitive damages, economic harms are considered less reprehensible as threats to the "health or safety of others." *Bains LLC v. Acro Prods. Co.*, 405 F.3d 764, 775 (9th Cir. 2005); *see also Calloway v. Reno*, 116 Nev. 250, 993 P.2d 1259, 1267 (2000) ("Purely economic loss is generally defined as 'the loss of the benefit of the user's bargain … including … pecuniary damage for inadequate value, … or consequent loss of profits."). Also, "socially valuable task[s]" or "conduct that might have some legitimate purpose" is considered less reprehensible than conduct that is discriminatory. *Bains LLC*, 405 F.3d at 775.

The only harm for which TeamHealth Plaintiffs presented evidence is that they received less payment than they demanded as reimbursement for certain out-of-network emergency medicine services. There is no evidence that these "underpayments" threatened anyone's health or physical safety; to the contrary, the only harm appears to be purely economic, in that TeamHealth Plaintiffs' parent company and investors received less of a windfall than they might have anticipated. Moreover, the Defendants' motive in paying less than TeamHealth Plaintiffs' full billed charges was not "evil" or fraudulent—the only testimony on this subject consistently affirmed that Defendants intended to control skyrocketing healthcare costs for their clients and members. On the evidence presented, TeamHealth Plaintiffs cannot be awarded punitive damages on their Unfair Claims Practices Act claim as a matter of law.

1. Punitive Damages Cannot Be Applied Against UHS or UMR Because They Are Not Insurers

The only cause of action for which TeamHealth Plaintiffs contend the jury can award punitive damages is their claim under the Unfair Claims Practices Act. *See* JPTO at 5–6. As explained above, this Act applies only to insurers and not to administrators of self-funded health benefits plans. For that reason, punitive damages cannot be awarded against UHS or UMR, who are not insurers and cannot be liable under the Act.

2. Punitive Damages Cannot Be Awarded on a Cause of Action that Sounds in Contract

TeamHealth Plaintiffs cannot obtain punitive damages against ***any*** Defendant because their cause of action under the Unfair Claims Practices Act sounds in contract, not in tort. NRS 42.005 permits punitive damages only "in an action for breach of an obligation not arising from contract," and the Nevada Supreme Court has ruled that punitive damages cannot be awarded under NRS 42.005 where an action "sounds in contract, and not in tort." *Rd. Highway Builders, LLC v. N. Nev. Rebar, Inc.*, 284 P.3d 377, 384 (Nev. 2012); *see also Sprouse v. Wentz*, 105 Nev. 597, 602, 781 P.2d 1136, 1140 (1989) ("[P]unitive damages must be based on an underlying cause of action ***not based on a contract theory***." (emphasis added)). This prohibition applies not just to breach of contract claims, but broadly to any cause of action that "arises from" or "sounds in" contract. *Frank Briscoe Co. v. Clark County*, 643 F. Supp. 93, 100 (D. Nev. 1986) (breach of warranty claim cannot support an award of punitive damages); *e.g.*, *Desert Salon Servs., Inc. v. KPSS, Inc.*, No. 2:12–CV–1886 JCM (CWH), 2013 WL 497599, at *5 (D. Nev. Feb. 6, 2013) (contract-based causes of action for intentional interference with contractual relations, intentional interference with prospective economic advantage, and breach of the implied covenant of good faith and fair dealing cannot support an award of punitive damages); *Franklin v. Russell Rd. Food & Beverage, LLC*, No. 14A709372, 2015 WL 13612028, at *13 (Nev. Dist. Ct. June 25, 2015) (claims alleging failure to pay Plaintiffs Nevada's minimum wage do not "sound in tort, and in fact, are based on a contract theory").

It is undisputed that TeamHealth Plaintiffs' Unfair Claims Practices Act sounds in contract: they have ***conceded*** that their claim sounds in contract, and this Court ***agreed***. *See* Ps' Opp. to

Mot. to Dismiss at 25–26 (May 29, 2020); Order Denying Mot. to Dismiss FAC ¶ 68. For that reason alone, punitive damages cannot be awarded as a matter of law.[12] NRS 42.005.

Because TeamHealth Plaintiffs' Unfair Claims Practices Act claim sounds in contract, and because that claim is the ***only*** predicate for punitive damages in this case, TeamHealth Plaintiffs as a matter of law cannot recover punitive damages.[13]

Moreover, the ordinary way that a insurer in Nevada may be held liable for punitive damages in Nevada is through a tortious breach of the implied covenant of good faith and fair dealing in the insurance contract with its insured. *See, e.g., Great Am. Ins. Co. v. Gen. Builders,*

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[12] Were this cause of action to sound in tort rather than contract as this Court has held, then TeamHealth Plaintiffs would have no standing to bring a cause of action under the Unfair Claims Practices Act. The Nevada Supreme Court has held on multiple occasions that NRS 686A.310 does not create a private right of action in favor of third-party claimants—as opposed to insureds—like TeamHealth Plaintiffs. *See, e.g., Fulbrook*, 2015 WL 439598, at *4 ("This statute, however, does not provide a private right of action to third-party claimants."); *Gunny*, 108 Nev. at 346) ("[W]e conclude that [plaintiff] has no private right of action as a third-party claimant under NRS 686A.310."); *see also* Mot. to Dismiss FAC at 23–24. TeamHealth Plaintiffs are judicially estopped from now arguing that this claim sounds in tort after convincing this Court that the claim was based on contract.

[13] Nor is TeamHealth Plaintiffs' Unfair Claims Practices Claim akin to a breach of the covenant of good faith and fair dealing between a insurer and an insured. Not only did TeamHealth Plaintiffs expressly abandon such a claim, 11/22/2021 Tr. 310:20-22 ("We're not pursuing bad faith as a basis for punitive damages."), but such a breach—even if proved—would amount only to *contractual* bad faith, not the kind of *tortious* bad faith necessary to sustain a claim for punitive damages. That is, in fact, why punitive damages against insurers are generally only available in claims by their insureds with whom they have, rather than an arm's length relationship, a special relationship of trust. *See, e.g., Great Am. Ins. Co. v. Gen. Builders, Inc.*, 113 Nev. 346, 354–56, 934 P.2d 257, 263 (1997). In *Great American Insurance Co.*, the Nevada Supreme Court explained that the breach in that situation is considered tortious because of the "inherently unequal bargaining positions" in the insurer-insured relationship, which is one of the "special relationships" creating duties akin to those of a fiduciary. *Id.* Absent that special relationship of trust and reliance, and where both parties are "experienced commercial entities represented . . . by professional and experienced agents," there is no tort liability to support a claim for punitive damages. *Id.* (vacating punitive damages award). Critically, the insurer's special relationship is specifically with its *insured*, not others to whom the insurer may owe contractual or other duties. *See Ins. Co. of the W. v. Gibson Tile Co., Inc.*, 122 Nev. 455, 462, 134 P.3d 698, 702 (2006). In *Insurance Co. of the West*, the Supreme Court held that an insurer acting as surety had no special relationship with its principal, so the insurer's breach was purely contractual, not tortious: "[t]herefore, as a matter of law, there was no basis for the jury's award of punitive damages." *Id.* at 464, 133 P.3d at 703.

Here, neither the Unfair Practices Act Claim nor the unjust enrichment claim is based on anything other than an arm's-length relationship between sophisticated parties. The fiduciary-like special relationship of trust applicable to the insurer-insured relationship is absent, and so is any tort that can sustain a claim for punitive damages.

Inc., 113 Nev. 346, 354–56, 934 P.2d 257, 263 (1997). In *Great American Insurance Co.*, the Nevada Supreme Court explained that the breach in that situation is considered tortious because of the "inherently unequal bargaining positions" in the insurer-insured relationship, which is one of the "special relationships" creating duties akin to those of a fiduciary. *Id.* Absent that special relationship of trust and reliance, and where both parties are "experienced commercial entities represented . . . by professional and experienced agents," there is no tort liability to support a claim for punitive damages. *Id.* (vacating punitive damages award). Critically, the insurer's special relationship is specifically with its *insured*, not others to whom the insurer may owe contractual or other duties. *See Ins. Co. of the W. v. Gibson Tile Co., Inc.*, 122 Nev. 455, 462, 134 P.3d 698, 702 (2006). In *Insurance Co. of the West*, the Supreme Court held that an insurer acting as surety had no special relationship with its principal, so the insurer's breach was purely contractual, not tortious: "[t]herefore, as a matter of law, there was no basis for the jury's award of punitive damages." *Id.* at 464, 133 P.3d at 703.

3. TeamHealth Plaintiffs Have Presented No Evidence of Oppression, Fraud, or Malice

NRS 42.005 requires "clear and convincing evidence" of "oppression, fraud or malice." NRS 42.005(1); *see also United Fire Ins. Co. v. McClelland*, 105 Nev. 504, 512, 780 P.2d 193, 198 (1989) (to obtain punitive damages, plaintiff must show evidence of "oppression, fraud, or malice"). Far from "clear and convincing" evidence, TeamHealth Plaintiffs have presented ***no*** evidence of fraud, oppression, or malice, that would permit a reasonable jury to award punitive damages under NRS 42.005.

a. No Evidence of Fraud

To prove fraud, TeamHealth Plaintiffs must prove (1) a false representation, (2) Defendants' knowledge or belief that the representation is false, (3) Defendants' intention to induce TeamHealth Plaintiffs' reliance on that representation, (4) TeamHealth Plaintiffs' justifiable reliance on the representation, and (5) damages. *Nev. State Educ. Ass'n v. Clark Cty. Educ. Ass'n*, 482 P.3d 665, 675 (2021).

TeamHealth Plaintiffs presented no evidence of any of these elements at trial, and therefore punitive damages cannot be awarded based on fraud. At most, TeamHealth Plaintiffs presented evidence that Defendants made some representations about FAIRHealth and Data iSight. *See* P363 (United Website Showing Fair Health Used as Benchmark); 11/3/2021 Tr. 27:24–37:4; 11/10/2021 Tr. 92:14–100:3, 104:6–109:23; 11/12/2021 Tr. 79:20–82:19, 85:6–88:6 (Mr. Haben's testimony that this P363 did not reveal any misrepresentations); P488 (United Healthcare Member Rights & Responsibilities Page). There is no evidence showing these representations were false, no evidence that TeamHealth Plaintiffs justifiably relied on these representations, and no evidence that these representations caused them to be harmed in any way. Indeed, TeamHealth Plaintiffs repeatedly argued to the jury that they had no choice but to treat Defendants' members by virtue of their legal obligations under EMTALA. *See, e.g.*, 11/2/2021 Tr. 30:7-31:10, 35:8-36:1 (opening argument discussing ER doctors' legal obligations under EMTALA); 11/15/2021 Tr. 154:14-21 (Dr. Scherr testifying to the same); 11/23/2021 Tr. 81:19-82:2 (Dr. Scherr disagreeing with Defendants' expert that ER providers are willing sellers because of EMTALA). Thus, representations about reimbursement criteria plainly could not have induced TeamHealth Plaintiffs to treat Defendants' members – by their own admission they had no such discretion.

The jury has discretion to award punitive damages only if it finds by clear and convincing evidence that the defendant was guilty of malice, fraud, or oppression in the conduct that provides the basis for liability. NRS 42.002. That is, to award punitive damages, the jury must find that Defendants acted fraudulently ***in their failure to negotiate*** equitable, fair, and prompt settlements in violation of the Unfair Claims Practices Act. The websites that TeamHealth Plaintiffs have offered into evidence have no connection with any failure to negotiate claims; those websites were published long before the dates of service on the At-Issue Claims. TeamHealth Plaintiffs therefore have not offered any evidence of fraud that could support an award of punitive damages.

b. No Evidence of Oppression or Malice

Oppression or malice requires that the defendant "knows of the probable harmful consequences of a wrongful act and willfully and deliberately fails to act to avoid those consequences." *Kinder Morgan Energy Partners, L.P. v. Claytor*, 130 Nev. 1205, *published at*

Nos. 60131, 60667, 2014 WL 7187204, at *4 (Nev. Dec. 16, 2014). To prove oppression or malice, TeamHealth Plaintiffs must prove "despicable conduct" that shows "a conscious disregard of the rights or safety of others." *Id.*; *see also Ainsworth v. Combined Ins. Co. of Am.*, 104 Nev. 587, 590, 763 P.2d 673, 675 (1988) (oppression is "a conscious disregard for the rights of others which constitute[s] an act of subjecting plaintiffs to cruel and unjust hardship"). Such "conscious disregard of the rights or safety of others" cannot, as a matter of law, include underpayments to TeamHealth Plaintiffs or their corporate parents, or a "strategy to terminate … contracts" with TeamHealth practice groups. *See* Ps' Resp. to Ds' Trial Br. re: Out-of-State Harms at 4. Such economic harms are not "reprehensible" in a way that could justify an award of punitive damages. *See Bains LLC*, 405 F.3d at 775.

TeamHealth Plaintiffs submitted no evidence that could support a finding of malice, fraud, or oppression. Indeed, there is no malice or oppression as a matter of law because Defendants ***paid*** the insurance claims at issue. *See Pioneer Chlor Alkali Co. v. Nat'l Union Fire Ins. Co.*, 863 F. Supp. 1237, 1250–51 (D. Nev. 1994) (acknowledging "difficulty constructing a factual situation where an insurer who violated [NRS 686A.310] could have done so with an oppressive or malicious intent yet not denied, or refused to pay, the claim"). Defendants cannot have had the "evil" state of mind required to prove malice or oppression—the only evidence concerning the states of mind of Defendants' executives shows that they were concerned about controlling costs for their clients and members, and this evidence concerns Defendants' out-of-network programs generally rather than the settlement of any particular At-Issue Claim. *See* 11/10/2021 Tr. 45:10–47:24 (Mr. Haben testified that Defendants' out-of-network programs are in place to help control costs and that they "continuously look at our out-of-network programs to make sure we're paying a fair and reasonable rate, and we're addressing costs."); 11/10/2021 Tr. 136:13–137:1 (Mr. Haben testified that Defendants reached out to Multiplan for help in controlling costs because "[c]lients were demanding better controls on medical costs, and they were looking for better solutions."); 11/11/2021 Tr. 23:21–24:4 (Mr. Haben testified that market intelligence revealed that Defendants were "behind our competitors" who were "doing a better job" to control client healthcare spend"); 11/15/2021 Tr. 199:14–23 (Mr. Ziemer testified that UMR has "a variety of programs under our

cost reduction and savings programs that are designed to help our clients control costs."); 11/12/2021 Tr. 215:22–23 (Ms. Paradise testified that "I'm focused on driving savings for the clients. I don't have accountability for any revenue related to the programs").

TeamHealth Plaintiffs both have failed to present evidence on a ***harm*** that could support punitive damages, and have failed to present evidence that Defendants had a state of mind that could support punitive damages.

Indeed, as discussed above, the very uncertainty of TeamHealth Plaintiffs' underlying claim that they have been underpaid precludes punitive damages. "In most instances, unless the insured would be entitled to a directed verdict on the underlying insurance claim, an arguable reason to deny the claim exists, precluding the imposition of punitive damages." 14A STEVEN PLITT ET AL., COUCH ON INSURANCE § 207:73 (3d ed. June 2021 update). As TeamHealth Plaintiffs cannot show such a clear entitlement to their billed charges, punitive damages are categorically improper.

D. Defendants Are Entitled to Judgment as a Matter of Law on TeamHealth Plaintiffs' Claim for Breach of Implied-in-Fact Contract

TeamHealth Plaintiffs claim that Defendants breached an implied-in-fact contract under which they had agreed to pay TeamHealth Plaintiffs their full billed charges for all out-of-network services indefinitely into the future. None of the evidence presented at trial even begins to prove the existence of such a contract. "[A]n implied-in-fact contract exists where the conduct of the parties demonstrates that they (1) intended to contract; (2) exchanged bargained-for promises; and (3) the terms of the bargain are sufficiently clear." *Magnum Opes Constr. v. Sanpete Steel Corp.*, 129 Nev. 1135 (2013) (citing *Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. 371, 379, 283 P.3d 250, 256 (2012)).[14] "The terms of an express contract are stated in words while those of

[14] Defendants cite *Magnum Opes* for its persuasive value, and its application of *Certified Fire*, not as precedent. NRAP 36(c)(3). Defendants note that this case has been cited by the Nevada Federal District Court as binding authority in this action. *See Fremont Emergency Servs. (Mandavia), Ltd. v. UnitedHealth Grp., Inc.*, 446 F. Supp. 3d 700, 705 (D. Nev. 2020).

an implied contract are manifested by conduct." *Smith*, 91 Nev. at 668, 541 P.2d at 664 (citing *Youngman v. Nev. Irrigation Dist.*, 70 Cal. 2d 240, 74 Cal. Rptr. 398, 449 P.2d 462 (1969)).

The evidence that TeamHealth Plaintiffs presented at trial shows that Defendants did ***not*** agree to pay them their full billed charges, and that Defendants in fact almost ***never*** paid their full billed charges. *See* 11/16/2021 Tr. 63:9-17 (Mr. Murphy testified that TeamHealth does "agree[] to discount to discount billed charges" to "get paid"); *id*. 65:17-22 (Mr. Murphy testified that reimbursement at less than billed charges was acceptable at time of claim submission); 11/17/21 Tr. 167:19-168:7 (Mr. Leathers, TeamHealth Plaintiffs' expert, testified that, prior to the period in dispute, Defendants paid TeamHealth Plaintiffs' full billed charges infrequently); 11/22/2021 Tr. 14-17 (Mr. Bristow testified that, prior to the period in dispute, Defendants paid TeamHealth Plaintiffs their full billed charges around 7% of the time). There is no evidence that Defendants intended to contract with TeamHealth Plaintiffs, no evidence that they promised to reimburse TeamHealth Plaintiffs at their full billed charges, and no evidence that Defendants agreed to any of the material terms of such of a contract. In fact, testimony from TeamHealth Plaintiffs' own former contract negotiator at trial explicitly contradicts TeamHealth Plaintiffs' contention that there was an implied-in-fact contract. 11/23/2021 Tr. 34:19-23 (Ms. Harris testifying that, once Fremont's contract with Sierra Health Plan of Nevada terminated, there was "no contract whatsoever between Sierra and Fremont."). Under these facts, judgment should be entered in Defendants' favor as a matter of law.

1. An Implied-in-Fact Contract Requires All Elements of Contract Formation

At the outset, an implied-in-fact contract has no different elements than an express written or oral contract, except that the elements are manifested by conduct and not words. "The distinction between express and implied in fact contracts relates only to the manifestation of assent; both types are based upon the expressed or apparent intention of the parties." *Cashill v. Second Jud. Dist. Ct. of State ex rel. Cty. of Washoe*, 128 Nev. 887, 381 P.3d 600 (2012). Thus, TeamHealth Plaintiffs must show that the parties: "(1) intended to contract; (2) exchanged

bargained-for promises; and (3) the terms of the bargain are sufficiently clear." *Magnum Opes*, 129 Nev. 1135, No. 60016, 2013 WL 7158997 (Table), at *3.[15]

2. No Intent to Contract

TeamHealth Plaintiffs presented no evidence at trial that shows that any Defendants ever intended to enter into a contract with TeamHealth Plaintiffs—or any evidence that TeamHealth Plaintiffs intended to enter into a contract with Defendants. Without this evidence, their implied-in-fact contract cause of action fails as a matter of law. "To find a contract implied-in-fact, the fact-finder must conclude that the parties intended to contract." *Certified Fire*, 128 Nev. at 379–80, 283 P.3d at 256; *see also Smith*, 91 Nev. at 669, 541 P.2d at 665 (citing *Horacek v. Smith*, 33 Cal. 2d 186, 199 P.2d 929 (1948)) ("In order to prevail on the theory of a contract implied in fact, the court would necessarily have to determine that both parties intended to contract, and that promises were exchanged.").

There is no evidence on record on which a jury could conclude the parties intended to contract.[16] The bare fact that TeamHealth Plaintiffs provided services to Defendants' insureds does not evidence an intent to contract. In *Steele v. EMC Mortg. Corp.*, 129 Nev. 1154 (2013), *published at* 2013 WL 5423081, the Nevada Supreme Court affirmed summary judgment on a contract claim where the plaintiff did not present evidence that she entered into a contract with the defendant, but relied only on the defendant's acquiescence to the plaintiffs' supposed performance. *Id*. at *1 ("Although appellant presented evidence that EMC Mortgage accepted loan payments from appellant and communicated with appellant regarding the loan's status, this conduct alone does not manifest the parties' intent to bind appellant to the terms of the loan so as to give rise to an implied contract between EMC Mortgage and appellant.").[17] Similarly here, TeamHealth

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[15] *See supra* note 12.

[16] In fact, TeamHealth Plaintiffs successfully moved *in limine* to exclude evidence that categorically disproves the parties' intention to contract. *See* Mot. for New Trial at n.1 and Discovery Errors Sections I.B.1, I.C.1 (discussing excluded evidence regarding failed negotiations for network contract between TeamHealth Plaintiff Fremont and Defendants).

[17] Cited for persuasive value, not as precedent. NRAP 36(c)(3).

Plaintiffs rely solely on the facts that they performed out-of-network emergency medicine services, and that Defendants reimbursed them for those services on behalf of their plan members. 11/16/2021 Tr. 65:7-10 (Mr. Murphy testified that billed charges should be awarded because "[w]e perform the service"); 11/15/2021 Tr. 154:14-21 (Dr. Scherr only testified that they have to treat patients by operation of law); 11/10/2021 Tr. 25:24-28:5 (Mr. Haben testified that the allowed amount payable to providers "is defined by the benefit plan" and is not the billed charges); *id.* 33:22-34:2 (Mr. Haben testified that the allowed amount for out-of-network claims is paid based on what is "[d]efined in the benefit plan"); 11/16/2021 Tr. 148:12-18 (Ms. Hare testified that HPN's & SHL's claims processing system is designed to reimburse claims based on plan documents and not full billed charges). That is not enough to show contract formation.

Testimony from TeamHealth Plaintiffs' own employees underscores that there was no intent to contract between the parties. 11/22/2021 Tr. 95:1-6 (Mr. Bristow, TeamHealth Plaintiffs' corporate representative, explained that TeamHealth Plaintiffs submitted claims from TeamHealth Plaintiff Fremont under the Tax Identification Number of TeamHealth Plaintiff Ruby Crest because "we [] want also [to] have access to that health plan contract with a group that's not contracted."); *id.* 99:18-22 (Mr. Bristow emailed his colleague suggesting to "sub-TIN all of the Fremont sites under the other Nevada entity that is not contracted, but is getting better reimbursement at Team Physicians of Mandavia); *id.* 106:21-107:3 (Mr. Bristow was informed that Ruby Crest was non-participating with Defendants, so there was no contract between the parties); 11/23/2021 Tr. 34:19-23 (Ms. Harris testifying that, once Fremont's contract with Sierra Health Plan of Nevada terminated, there was "no contract whatsoever between Sierra and Fremont.").

If anything, Defendants' prior conduct establishes that there was ***no agreement*** to pay the TeamHealth Plaintiffs' full billed charges. TeamHealth Plaintiffs submitted evidence detailing Defendants' payments for the thousands of At-Issue Claims, which shows that Defendants rarely paid TeamHealth Plaintiffs' full billed charges. P473. "[T]he fact of agreement may be implied from a course of conduct in accordance with its existence," but the course of conduct here implies exactly the opposite of what TeamHealth Plaintiffs contend. 17A C.J.S. Contracts § 375, at 425

(1963). This is not a case in which a contract is implied because the parties "repeatedly adhered to" the terms of a contract "in their previous course of dealing." *Reno Club v. Young Inv. Co.*, 64 Nev. 312, 334, 182 P.2d 1011, 1021 (1947). Defendants' course of conduct repeatedly repudiates any notion that Defendants agreed to pay TeamHealth Plaintiffs their full billed charges on each reimbursement claim for out-of-network emergency medicine services.

There is no evidence that shows Defendants communicated by word and deed that that they intended to contract with TeamHealth Plaintiffs at any specific reimbursement rate for the disputed emergency medicine services, much less the TeamHealth Plaintiffs' full billed charges. In fact, TeamHealth Plaintiffs successfully moved to exclude any such evidence of contract negotiations. *See* 10/20/21 Tr. at 17:21–24. Regardless, that Defendants may have been willing to contract with TeamHealth Plaintiffs, had they been willing to agree to different terms, does not evidence that Defendants did agree to any particular contractual terms. *See* 11/16/2021 Tr. 63:9-17 (Mr. Murphy testified that TeamHealth does "agree[] to discount to discount billed charges" to "get paid"); *id.* 65:17-22 (Mr. Murphy testified that a certain reimbursement less than billed based on a wrap arrangement was acceptable at time of claim submission). "With respect to contract formation, preliminary negotiations do not constitute a binding contract unless the parties have agreed to all material terms." *May v. Anderson*, 121 Nev. 668, 672, 119 P.3d 1254, 1257 (2005). There is no evidence of such an agreement here.

3. No Promises Exchanged

Another essential element of contract formation is that "promises were exchanged" through the parties' conduct. *Smith*, 91 Nev. at 669, 541 P.2d at 665 (citing *Horacek v. Smith*, 33 Cal. 2d 186, 199 P.2d 929 (1948)); *see also Certified Fire*, 128 Nev. at 379–80, 283 P.3d at 256 ("To find a contract implied-in-fact, the fact-finder must conclude that … promises were exchanged."); *Magnum Opes Constr. v. Sanpete Steel Corp.*, 129 Nev. 1135 (2013) (citing *Certified Fire*, 283 P.3d at 256) ("Turning to the parties' substantive arguments, an implied-in-fact contract exists where the conduct of the parties demonstrates that they … exchanged bargained-for promises.").[18]

[18] *See supra* note 12.

TeamHealth Plaintiffs presented no evidence at trial that shows the Defendants exchanged promises with TeamHealth Plaintiffs concerning the rate of payment for out-of-network emergency medicine services. 11/16/2021 Tr. 65:7-10 (Mr. Murphy testified that billed charges should be awarded because "[w]e perform the service"); 11/15/2021 Tr. 154:14-21 (Dr. Scherr only testified that they have to treat patients by operation of law); 11/10/2021 Tr. 25:24-28:5 (Mr. Haben testified that the allowed amount payable to providers "is defined by the benefit plan" and is not the billed charges); *id.* 33:22-34:2 (Mr. Haben testified that the allowed amount for out-of-network claims is paid based on what is "[d]efined in the benefit plan"). As discussed above, evidence of the parties' contract negotiations was excluded from evidence. TeamHealth Plaintiffs have not proved that Defendants exchanged promises.

4. No Meeting of the Minds on Material Terms

TeamHealth Plaintiffs also did not present any evidence at trial from which a jury could infer the terms of an implied-in-fact contract. "A valid contract cannot exist when material terms are lacking or are insufficiently certain and definite" for a court "to ascertain what is required of the respective parties" and to "compel compliance" if necessary. *Grisham v. Grisham*, 128 Nev. 679, 685, 289 P.3d 230, 235 (2012); *see also May*, 121 Nev. at 672, 119 P.3d at 1257 ("A valid contract cannot exist when material terms are lacking or are insufficiently certain and definite."). Here, there are at least two material terms that TeamHealth Plaintiffs did not established through evidence: price and contract term.

Price in particular is a material term to any contract for Defendants to pay TeamHealth Plaintiffs a specific rate for their services. Courts commonly find there to be no contract formation where the parties have not agreed to a price. *E.g.*, *Certified Fire*, 128 Nev. at 380, 283 P.3d at 256 ("There are simply too many gaps to fill in the asserted contract for quantum meruit to take hold. Precision never agreed to a contract for only design-related work, ***the parties never agreed to a price for that work***, and they disputed the time of performance." (emphasis added)); *Matter of Est. of Kern*, 107 Nev. 988, 991, 823 P.2d 275, 276–77 (1991) ("In the case at bar, several essential elements of a valid contract are missing. … [M]aterial terms such as subject matter, ***price***, payment terms, quantity, and quality are either altogether lacking or insufficiently certain and definite to

support specific performance." (emphasis added)). TeamHealth Plaintiffs did not present a shred of evidence that Defendants affirmatively agreed to pay them at the full billed charges or in any other amount. Indeed, within the span of this litigation they have changed their own view of what Defendants supposedly agreed to pay for out-of-network services. *See United Healthcare Ins. Co. v. Eighth Jud. Dist. Ct. in & for Cty. of Clark*, 489 P.3d 915 (Nev. 2021) (noting that "[t]he providers alleged an implied-in-fact contract to provide emergency medical services to United's plan members ***in exchange for payment at a usual and customary rate***, and that United breached this contract by not doing so.").

Nor have Plaintiffs submitted any evidence of the duration or term of the implied-in-fact contract. To the contrary, TeamHealth Plaintiffs objected to Defendants questioning witnesses on this topic. *See* 11/10/2021 Tr. 168:22-169:4. TeamHealth Plaintiffs' position appears to be that the duration is indefinite—that Defendants somehow agreed to pay them at their full rates forever into the future. Yet TeamHealth Plaintiffs cannot point to a single piece of evidence that indicates anyone acting as an agent of the Defendants, by their actions, agreed to a specific term for this contract to persist in perpetuity. To the contrary, Defendants' witnesses have denied having agreed to any such term. 11/10/2021 Tr. 168:16–21 (testifying that the only contracts that Defendants enter into "need[] to be in writing on contractual paper that was drafted by our attorneys and approved and used and available through a database"); Joint Submission of Dep. Clips for Trial Record as Played on Nov. 12, 2021 39:21–41:23. In the context of an agreement to pay Plaintiffs' full billed charges, where payors and providers typically agree to far lower rates as part of network agreements that last only a few years, the contract duration is a material term of the contract. Without a meeting of the minds on that term, there can be no implied contract. *See Kern*, 107 Nev. at 991.

Based on the evidence at trial, any verdict finding that Defendants formed an implied-in-fact contract with TeamHealth Plaintiffs to pay their full billed charges for out-of-network emergency medicine services would be contrary law, and Defendants are entitled to judgment as a matter of law.

E. If the Court Disagrees that Defendants are Entitled to Judgment as a Matter of Law on TeamHealth Plaintiffs' Implied-in-Fact Contract Claims, Then TeamHealth Plaintiffs are Not Entitled to Judgment as a Matter of Law on their Unjust Enrichment Claims

As a matter of law, where, as here, a jury finds there is an enforceable contract between parties, the remedy of unjust enrichment is barred. The purpose of the remedy of unjust enrichment is to compensate a party that confers a benefit with reasonable expectation of payment and without an express agreement memorializing that expectation. Richard A. Lord, Williston on Contracts § 68:1, at 24 (4th ed. 2003). As comment e. to the Restatement (Third) of Restitution and Unjust Enrichment § 49 notes, the remedy of quantum meruit is "regarded in modern law" as an instance of "unjust enrichment rather than contract." This is well-established established in Nevada. *See, e.g.*, *Richey v. Axon Enters., Inc.*, 437 F. Supp. 3d 835, 849 (D. Nev. 2020) ("As a quasi-contract claim, unjust enrichment is unavailable when there is an enforceable contract between the parties."); *Leasepartners Corp. v. Robert L. Brooks Tr. Dated Nov. 12, 1975*, 113 Nev. 747, 756 (1997) ("The doctrine of unjust enrichment or recovery in quasi contract applies to situations where there is no legal contract but where the person sought to be charged is in possession of money or property which in good conscience and justice he should not retain but should deliver to another or should pay for.").

Here, the jury found there was an implied-in-fact contract between TeamHealth Plaintiffs and Defendants. 11/29/21 Special Verdict Form. TeamHealth Plaintiffs' unjust enrichment claims thus fail as a matter of law, and Defendants are entitled to judgment as a matter of law on those claims. *See* 12/6/2021 Tr. 51:13-18.

F. Defendants Are Entitled to Judgment as a Matter of Law on TeamHealth Plaintiffs' Prompt Pay Act Claim

Neither the Insurance Code nor the Prompt Pay Act itself affords TeamHealth Plaintiffs a private right of action against Defendants. The Nevada Supreme Court has ruled that "the ***insurance commissioner alone has authority to enforce*** the insurance code," *Joseph v. Hartford Fire Ins. Co.*, No. 2:12–CV–798 JCM (CWH), 2014 WL 2741063, at *2 (D. Nev. June 17, 2014) (emphasis added), and that the Insurance Commissioner has "exclusive jurisdiction in regulating the subject of trade practices in the business of insurance." *Allstate Ins. Co. v. Thorpe*, 123 Nev.

565, 572, 170 P.3d 989, 994 (2007). No private right of action exists under the Prompt Payment Act. And even if it did, TeamHealth Plaintiffs are barred from asserting that right of action as a matter of law because they failed to exhaust available administrative remedies created by that Act.

1. TeamHealth Plaintiffs Have No Private Right of Action Under the Prompt Payments Act

No private right of action exists on the face of the Prompt Payments Act. The plain meaning of NRS 690B.012 is that an interest penalty will be imposed if an insurance company has determined that payment is owed, and failed to pay within thirty days. NRS 690B.012(4) ("If the approved claim is not paid within that period, the insurer shall pay interest on the claim … ."). The interest that accrues on the insurance claim acts as a punitive measure, which the Nevada Legislature has imposed on insurance companies to compel them to pay the policyholder's covered medical bills promptly. The statute does not impose any other liability onto insurers, and NRS 690B.012 does not create a private right of action even for policyholders, much less to third-party medical providers such as TeamHealth Plaintiffs.

If there were a private right of action implied in NRS 690B.012—and nothing in the text of the statute suggests there is—that right of action would belong to the ***insured***, not to TeamHealth Plaintiffs. The statute governs how an insurer approves and pays "a claim of its insured relating to a contract of casualty insurance." NRS 690B.012(1). The rights and duties of the statute therefore only accrue and flow to the policyholder, not to third-party medical providers. TeamHealth Plaintiffs are not insureds of Defendants under any contract, and they have repeatedly disclaimed any right to recover by standing in the shoes of insureds through an AOB. SAC at 2 n.1 (Plaintiffs "do not assert claims that are dependent on the existence of an assignment of benefits ("AOB") from any of Defendants' Members.").[19] TeamHealth Plaintiffs have no statutory standing to sue under the Prompt Payments Act, and Defendants are entitled to judgment as a matter of law.

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[19] If TeamHealth Plaintiffs were to rely on EOBs, their cause of action would be preempted by ERISA. *See supra* note 8.

Even if there was a private right of action of which TeamHealth Plaintiffs could avail themselves, TeamHealth Plaintiffs did not prove, nor did they even allege, that Defendants did not pay for the At-Issue claims within 30 days. 11/16/2021 Tr. 226:23-227:10 (Mr. Leathers testified that Defendants' data for the At-Issue Claims includes reimbursement amounts); *id.* 233:12-22 (Mr. Leathers testified that he analyzed claims that were allegedly underpaid as opposed to not paid). In fact, TeamHealth Plaintiffs' corporate representative expressly admitted that Defendants paid ***every single*** At-Issue claim within 30 days. 11/22/2021 Tr. 73:24-74:14. Instead, TeamHealth Plaintiffs' entire case hinged on whether Defendants paid an appropriate amount for each claim. Because TeamHealth Plaintiffs did not present any evidence showing a violation of the Prompt Pay Act, Defendants are entitled to judgment as a matter of law on this claim.

2. TeamHealth Plaintiffs Failed to Exhaust Administrative Remedies

Defendants asserted an affirmative defense of failure to exhaust administrative remedies, and the evidence shows that Plaintiffs did not exhaust the available administrative remedies for their Prompt Payment Act claim. "[A] person generally must exhaust all available administrative remedies before initiating a lawsuit, and failure to do so renders the controversy nonjusticiable. *Allstate*, 123 Nev. at 568, 571–72. Assuming the Prompt Payments Act creates a private right of action for third parties—notwithstanding the text and purpose of the statute—plaintiffs must first exhaust all available administrative remedies created by the Act.

The Insurance Code creates an administrative process that TeamHealth Plaintiffs were required to exhaust before coming to court. The Insurance Code allows a person to apply for a hearing of the Insurance Commissioner where that person is aggrieved by a "failure of the Commissioner to" enforce the Insurance Code. NRS 679B.310(2)(b); *see also Joseph*, 2014 WL 2741063, at *2 ("the insurance commissioner alone has authority to enforce the insurance code"). TeamHealth Plaintiffs were required to make such an application within 60 days of the alleged failure by Defendants to provide timely reimbursement. *See id.* On such an application, the Insurance Commission holds a hearing and makes a decision that can be appealed. NRS 679B.310 (4)–(5); NRS 679B.370. Within 30 days of an adverse final ruling rendered by the Insurance Commissioner, the TeamHealth Plaintiffs had the option of seeking judicial review of the

Commissioner's decision. NRS 233B.130; *see also* NRS 233B.133 (outlining briefing process for judicial review).

TeamHealth Plaintiffs presented no evidence that they complied with any of this administrative process. TeamHealth Plaintiffs have not alleged or proven exhaustion of the available administrative remedies, Defendants are entitled to judgment as a matter of law on TeamHealth Plaintiffs' claim under the Prompt Payments Act.

G. TeamHealth Plaintiffs' Causes of Action Are Preempted by ERISA

Under ERISA § 514, a state-law claim conflicts with ERISA and is expressly preempted if it "relates to" an employee benefit plan governed by ERISA. 29 U.S.C. § 1144(a). This action is undoubtedly related to employee benefit claims, and all of TeamHealth Plaintiffs' causes of action are preempted by ERISA.

Plaintiffs' claims are conflict preempted because they seek to compel thousands of different ERISA-governed plans administered by Defendants to pay them their unilaterally set charges without reference to the specific benefit rates established by the terms of each governing health plan—and without any of the plans ever having agreed to pay anything other than the plan benefit rates. For instance, if the governing plan adopted an out-of-network program that limited the member's benefit for out-of-network ER service to 200% of Medicare, any judgment finding that Nevada common law imposes an obligation on Defendants to pay the TeamHealth Plaintiffs their full billed charges, substantially above that out-of-network benefit, necessarily conflicts with the terms of the ERISA plan. D5499 (plan document instructing to use OCM exclusively); 11/10/2021 Tr. 126:4–131:4 (Mr. Haben testified that testimony discussing the plan document contained in D5499 required the OCM program to price out-of-network claims); 11/15/2021 Tr. 136:22-140:12 (Ms. Paradise testified that the usual and customary language in P146, a certificate of coverage for a fully insured plan, did "not suggest . . . that the physician reasonable and customary program established by FAIR Health would be used to reimburse an[] out-of-network emergency service"); *id.* 137:25-138:7 (Ms. Paradise testified that plan document must be reviewed to determine what out-of-network program applies); 11/16/2021 Tr. 142:24-143:6 (Ms. Hare testified that plan documents dictate out-of-network reimbursement); *id.* 148:12-18 (Ms.

Hare testified that HPN's & SHL's claims processing system is designed to reimburse claims based on plan documents and not full billed charges). But ERISA requires the Defendants to "specify the basis on which payments are made to and from [their plans]" and to administer their plans "in accordance with the documents and instruments governing the plan[s]." 29 U.S.C. § 1102(b)(4); 29 U.S.C. § 1104(a)(1)(D). Any verdict that awards remedies in excess of what Defendants owed under the governing plans would be contrary to ERISA.

ERISA preempts any state law that would, as Plaintiffs request, rewrite the terms of the governing health plans to require payment for out-of-network ER services at amounts higher than permitted by the plans. Indeed, it is well established that ERISA preempts implied-in-fact contract claims such as the TeamHealth Plaintiffs. *Aetna Life Ins. Co. v. Bayona*, 223 F.3d 1030, 1034 (9th Cir. 2000) ("We have held that ERISA preempts common law theories of breach of contract implied in fact…"); *Blau v. Del Monte Corp.*, 748 F.2d 1348, 1356 (9th Cir. 1984) (breach of implied-in-fact contract claim was conflict preempted), *abrogated on other grounds in Dytrt v. Mountain States Tel. & Tel. Co.*, 921 F.2d 7889, 7894 n.4 (9th Cir. 1990); *Parlanti v. MGM Mirage*, 2:05-CV-1259-ECR-RJJ, 2006 WL 8442532, at *6 (D. Nev. Feb. 15, 2006) (breach of contract claim conflict preempted).

III. CONCLUSION

For the foregoing reasons, this Court should grant Defendants judgment as a matter of law on all causes of action.

Dated this 6th day of April, 2022.

/s/ Abraham G. Smith

Daniel F. Polsenberg, Esq.
Joel D. Henriod, Esq.
Abraham G. Smith, Esq.
Lewis Roca Rothgerber Christie LLP
3993 Howard Hughes Parkway
Suite 600
Las Vegas, Nevada 89169-5996
Telephone: (702) 949-8200

D. Lee Roberts, Jr., Esq.
Colby L. Balkenbush, Esq.
Brittany M. Llewellyn, Esq.
Phillip N. Smith, Jr., Esq.

Dimitri D. Portnoi, Esq.(*Pro Hac Vice*)
Jason A. Orr, Esq. (*Pro Hac Vice)*
Adam G. Levine, Esq. *(Pro Hac Vice)*
Hannah Dunham, Esq. *(Pro Hac Vice)*
Nadia L. Farjood, Esq. (*Pro Hac Vice*)
O'Melveny & Myers LLP
400 S. Hope St., 18th Floor
Los Angeles, CA 90071

K. Lee Blalack, II, Esq.(*Pro Hac Vice)*
Jeffrey E. Gordon, Esq. *(Pro Hac Vice)*
Kevin D. Feder, Esq. *(Pro Hac Vice)*
Jason Yan, Esq. *(Pro Hac Vice)*

Marjan Hajimirzaee, Esq.
WEINBERG, WHEELER, HUDGINS,
GUNN & DIAL, LLC
6385 South Rainbow Blvd.
Suite 400
Las Vegas, Nevada 89118

Attorneys for Defendants

O'Melveny & Myers LLP
1625 Eye St. NW
Washington, DC 20006

Paul J. Wooten, Esq. *(Pro Hac Vice)*
Philip E. Legendy *(Pro Hac Vice)*
O'Melveny & Myers LLP
Times Square Tower, Seven Times Square
New York, NY 10036

CERTIFICATE OF SERVICE

I hereby certify that on the 6th day of April, 2022, a true and correct copy of the foregoing "**DEFENDANTS' RENEWED MOTION FOR JUDGMENT AS A MATTER OF LAW"** was electronically filed and served on counsel through the Court's electronic service system pursuant to Administrative Order 14-2 and N.E.F.C.R. 9, via the electronic mail addresses noted below, unless service by another method is stated or noted:

Pat Lundvall, Esq.
Kristen T. Gallagher, Esq.
Amanda M. Perach, Esq.
McDonald Carano LLP
2300 W. Sahara Ave., Suite 1200
Las Vegas, Nevada 89102
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Justin C. Fineberg
Martin B. Goldberg
Rachel H. LeBlanc
Jonathan E. Feuer
Lash & Goldberg LLP
Weston Corporate Centre I
2500 Weston Road Suite 220
Fort Lauderdale, Florida 33331
jfineberg@lashgoldberg.com
mgoldberg@lashgoldberg.com
rleblanc@lashgoldberg.com
jfeuer@lashgoldberg.com

Joseph Y. Ahmad (admitted *pro hac vice*)
John Zavitsanos (admitted *pro hac vice*)
Jason S. McManis (admitted *pro hac vice*)
Michael Killingsworth (admitted *pro hac vice*)
Louis Liao (admitted *pro hac vice)*
Jane L. Robinson (admitted *pro hac vice*)
P. Kevin Leyendecker (admitted *pro hac vice*)
Ahmad, Zavitsanos, Anaipakos, Alavi & Mensing,
1221 McKinney Street, Suite 2500
Houston, Texas 77010
Telephone: 713-600-4901
joeahmad@azalaw.com;jzavitsanos@azalaw.com
jmcmanis@azalaw.com;mkillingsworth@azalaw.com
lliao@azalaw.com; jrobinson@azalaw.com
kleyendecker@azalaw.com

Attorneys for Plaintiffs

Judge David Wall, Special Master
Attention: Mara Satterthwaite & Michelle Samaniego
JAMS
3800 Howard Hughes Parkway
11th Floor
Las Vegas, NV 89123
msatterthwaite@jamsadr.come
msamaniego@jamsadr.com

/s/ Cynthia Kelley
An employee of Lewis Roca Rothgerber Christie LLP

EXHIBIT 7

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MOT

D. Lee Roberts, Jr., Esq.
Nevada Bar No. 8877
lroberts@wwhgd.com
Colby L. Balkenbush, Esq.
Nevada Bar No. 13066
cbalkenbush@wwhgd.com
Brittany M. Llewellyn, Esq.
Nevada Bar No. 13527
bllewellyn@wwhgd.com
Phillip N. Smith, Jr., Esq.
Nevada Bar No. 10233
psmithjr@wwhgd.com
Marjan Hajimirzaee, Esq.
Nevada Bar No. 11984
mhajimirzaee@wwhgd.com
WEINBERG, WHEELER, HUDGINS, GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
Telephone: (702) 938-3838
Facsimile: (702) 938-3864

Daniel F. Polsenberg, Esq.
Nevada Bar No. 2376
dpolsenberg@lewisroca.com
Joel D. Henriod, Esq.
Nevada Bar No. 8492
jhenriod@lewisroca.com
Abraham G. Smith, Esq.
Nevada Bar No. 13250
asmith@lewisroca.com
Lewis Roca Rothgerber Christie LLP
3993 Howard Hughes Parkway, Suite 600
Las Vegas, Nevada 89169-5996
Telephone: (702) 949-8200

Dimitri D. Portnoi, Esq.(*Admitted Pro Hac Vice*)
dportnoi@omm.com
Jason A. Orr, Esq. (*Admitted Pro Hac Vice)*
jorr@omm.com
Adam G. Levine, Esq. *(Admitted Pro Hac Vice)*
alevine@omm.com
Hannah Dunham, Esq. *(Admitted Pro Hac Vice)*
hdunham@omm.com
Nadia L. Farjood, Esq. (*Admitted Pro Hac Vice*)
nfarjood@omm.com
O'Melveny & Myers LLP
400 S. Hope St., 18th Floor
Los Angeles, CA 90071
Telephone: (213) 430-6000

K. Lee Blalack, II, Esq.(*Admitted Pro Hac Vice)*
lblalack@omm.com
Jeffrey E. Gordon, Esq. *(Admitted Pro Hac Vice)*
jgordon@omm.com
Kevin D. Feder, Esq. *(Admitted Pro Hac Vice)*
kfeder@omm.com
Jason Yan, Esq. *(Admitted Pro Hac Vice)*
jyan@omm.com
O'Melveny & Myers LLP
1625 Eye St., N.W.
Washington, D.C. 20006
Telephone: (202) 383-5374

Paul J. Wooten, Esq. *(Admitted Pro Hac Vice)*
pwooten@omm.com
Philip E. Legendy *(Admitted Pro Hac Vice)*
plegendy@omm.com
O'Melveny & Myers LLP
Times Square Tower, Seven Times Square
New York, NY 10036
Telephone: (212) 728-5857

Attorneys for Defendants

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation,

Plaintiffs,

Case No.: A-19-792978-B
Dept. No.: 27

HEARING REQUESTED

DEFENDANTS' MOTION FOR REMITTITUR AND TO ALTER OR AMEND THE JUDGMENT

LEWIS ROCA

vs.

UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20,

Defendants.

Defendants UnitedHealthcare Insurance Company ("UHIC"), United HealthCare Services Inc. ("UHS"), which does business as UnitedHealthcare or "UHC" and through UHIC), UMR, Inc. ("UMR"), Sierra Health and Life Insurance Company ("SHL"), and Health Plan of Nevada, Inc. ("HPN") (collectively, "Defendants"), move the Court to remit the excessive award of punitive damages in the judgment pursuant to NRCP 59(a), NRCP 59(e), and U.S. Const. amend. XIV, § 2.

As discussed in the concurrently filed Rule 50(b) motion, liability should not have been found as a matter of law, including because TeamHealth Plaintiffs[1] do not have standing to bring an Unfair Claims Practices Act cause of action. Therefore, the punitive damages award cannot stand. *See Wolf v. Bonanza Inv. Co.*, 77 Nev. 138, 143, 360 P.2d 360, 362 (1961) ("[I]n the absence of a judgment for actual damages, there [cannot be] a valid judgment for exemplary damages.").

But even assuming that Defendants were liable, the jury clearly rejected TeamHealth Plaintiffs' claim that they were entitled to their full billed charges. There is simply no justification for the colossal $60 million punitive damages award. "Awards of punitive damages are generally limited by procedural and substantive due process concerns." *Wyeth v. Rowatt*, 126 Nev. 446, 474, 244 P.3d 765, 784 (2010), *citing State Farm Mut. Automobile Ins. Co. v. Campbell*, 538 U.S. 408,

[1] The "TeamHealth Plaintiffs" collectively refers to the three Plaintiffs that initiated this action, each of which is owned by and affiliated with TeamHealth Holdings, Inc.: Fremont Emergency Services (Mandavia), Ltd. ("Fremont"), Team Physicians of Nevada-Mandavia, P.C. ("TPN"), and Crum, Stefanko and Jones, Ltd., d/b/a Ruby Crest Emergency Medicine ("Ruby Crest").

416–17, 123 S. Ct. 1513 (2003). And in Nevada, as in many other states, they are also limited by statute. NRS 42.005(1).[2] Here the punitive damages award blew past both limitations. This Court should now vacate, or at the very least significantly reduce, that award.

I.

THE PUNITIVE DAMAGES ARE UNCONSTITUTIONALLY EXCESSIVE

The punitive damages award in this case exceeds constitutional limits. Even when punitive damages are not limited by the cap of NRS 42.005, the federal and state Due Process Clauses independently prohibit the imposition of "grossly excessive" punishments on a tortfeasor. *Bongiovi v. Sullivan*, 122 Nev. 556, 582–83, 138 P.3d 433, 451–52 (2006); *BMW of N. Am., Inc. v. Gore*, 517 U.S. 559, 562, 116 S. Ct. 1589, 1592 (1996).

A. The Guideposts for Assessing Constitutionality

This Court must review the "excessiveness of a punitive damages award" using "the federal standard's three guideposts." *Bongiovi*, 122 Nev. at 683, 138 P.3d at 452. Those guideposts are: "(1) the degree of reprehensibility of the defendant's misconduct; (2) the disparity between the actual or potential harm suffered by the plaintiff and the punitive damages award; and (3) the difference between the punitive damages awarded by the jury and the civil penalties authorized or imposed in comparable cases." *Id.*; *State Farm*, 538 U.S. at 418. And because consideration of these guideposts is an "application of law," no deference to the jury's verdict is warranted. *Id.* (internal quotation marks omitted). Considering those guideposts here, this Court should conclude that the award of punitive damages against Defendants was grossly excessive.

B. This Case Does Not Exhibit Reprehensibility Necessary to Justify $60 Million in Punitive Damages

Reprehensibility of the defendant's conduct is "[p]erhaps the most important indicium of

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[2] Defendants understand that this Court previously rejected application of the statutory cap in NRS 42.005(1). While Defendants preserve and renew their objection to that ruling here, the discussion on constitutional limits in section I below is an independent basis compelling remittitur of the punitive-damages award. This Court should therefore grant remittitur even if it does not reconsider the application of NRS 42.005(1).

the reasonableness of a punitive damages award." *BMW of North America v. Gore*, 517 U.S. 559, 575 (1996). Importantly, for purposes of the Court's post-judgment scrutiny of the judgment for excessiveness, the question of degree of any reprehensibility is distinct from jury's finding. "That conduct is sufficiently reprehensible to give rise to tort liability, and even a modest award of exemplary damages[,]" as a threshold matter, "does not establish the high degree of culpability that warrants a ***substantial*** punitive damages award." *Id*., 517 U.S. at 580 (emphasis added). As the United States Supreme Court has said, "[i]t should be presumed a plaintiff has been made whole for his injuries by compensatory damages, so punitive damages should only be awarded if the defendant's culpability, after having paid compensatory damages, is ***so*** reprehensible as to warrant the imposition of further sanctions to achieve punishment or deterrence." *State Farm*, 538 U.S. at 419 (emphasis added).

1. The *Gore* Factors for Determining the Degree of Reprehensibility Militate Against a Large Award

In *Gore*, the US Supreme Court identified five factors courts should consider in evaluating the reprehensibility of a defendant's conduct. 517 U.S. at 576-80. Each factor weighs heavily in favor of reducing this punitive damages award.

Whether the harm suffered by the plaintiff is "purely economic in nature." 517 U.S. at 576. The harm in this case was "purely economic." Consequently, this factor weighs against reprehensibility. In analyzing whether conduct is outrageous or reprehensible in a way that permits an award of punitive damages, economic harms are considered less reprehensible as threats to the "health or safety of others." *Bains LLC v. Acro Prods. Co.*, 405 F.3d 764, 775 (9th Cir. 2005) ; *see also Calloway v. Reno*, 116 Nev. 250, 993 P.2d 1259, 1267 (2000) ("Purely economic loss is generally defined as 'the loss of the benefit of the user's bargain . . . including . . . pecuniary damage for inadequate value, . . . or consequent loss of profits."). Also, "socially valuable task[s]" or "conduct that might have some legitimate purpose" is considered less reprehensible than conduct that is discriminatory. *Bains LLC*, 405 F.3d at 775. TeamHealth Plaintiffs argued to the jury that an excessive punitive damages award was justified "[b]ecause [Defendants'] greed is utterly, totally uninhibited and unhinged." 12/07/2021 Tr. 99:10. But this statement at

best only demonstrates that TeamHealth Plaintiffs suffered purely economic harm. TeamHealth Plaintiffs did not present and cannot now point to *any* evidence that establishes that the conduct here resulted in any physical harm. In the absence of physical harm, this factor weighs in favor of reducing the punitive damages award. *See State Farm*, 538 U.S. at 419, 426, 123 S.Ct. 1521, 1524-25; *Bains LLC*, 405 F.3d at 775.

Whether the defendant's "conduct evinced . . . indifference to or reckless disregard for the *health and safety* of others." 517 U.S. at 576. This is a business case. As set out more fully in Defendants' Motion for New Trial Due to Trial Errors, the only harm for which TeamHealth Plaintiffs presented evidence is economic: they received less payment than they demanded as reimbursement for certain out-of-network emergency medicine services. There is no evidence that these "underpayments" threatened anyone's health or physical safety—rather, TeamHealth Plaintiffs' parent company and investors received less of a windfall than they might have anticipated. There was no evidence presented that doctors' compensation was reduced or any emergency room in Nevada was forced to close due to these alleged underpayments. And there was no evidence presented that patient care was impacted.by these alleged underpayments. Moreover, the Defendants' motive in paying less than TeamHealth Plaintiffs' full billed charges was not "evil" or fraudulent—the only testimony on this subject consistently affirmed that Defendants intended to control skyrocketing healthcare costs for their clients and members. This factor weighs against reprehensibility.

Whether the plaintiff was "financially vulnerable." 517 U.S. at 576. While TeamHealth Plaintiffs claimed that Defendants' low reimbursement rates caused financial harm to TeamHealth Plaintiffs' business, *see, e.g.*, 11/12/2021 Tr. 115:19-24 (opposing counsel testifying that "[Defendants] shouldn't have cut [TeamHealth Plaintiffs'] reimbursement by taking the money out of our pocket and putting it into yours."), the same can be said of almost any business venture. TeamHealth Plaintiffs were not uniquely vulnerable. For instance, this case does not involve individuals with low incomes or senior citizens with fixed incomes, which are the types of circumstances this factor typically contemplates. *See, e.g., Lompe v. Sunridge Partners, LLC*, 818 F.3d 1041, 1066 (10th Cir. 2016) (concluding plaintiff as a low-income college student was

financially vulnerable). And even considering the business enterprise, TeamHealth Plaintiffs were *never* on a financial precipice such that Defendants' reimbursement rates imperiled their commercial viability.[3] Indeed, opposing counsel inflamed the jury's passions by depicting TeamHealth Plaintiffs as righteous business entities that brought suit to look after smaller market players, including mom and pop practices, because they have the resources to take on a litigant with the size and power of Defendants. *See* 11/12/2021 Tr. 111:11-16 ("do you think that a mom and pop operation with four, or five, or six doctors has the resources to take on UnitedHealthcare?"); 11/23/2021 Tr. 151:4-8 ("[I]f you're a doctor in a practice of three or four people . . . are you really going to hire a lawyer or do something about it? I mean [Defendants] know that they have all the power and all the leverage"); 11/23/2021 Tr. 145:25-9. TeamHealth Plaintiffs presented no evidence regarding doctor compensation, let alone any evidence showing doctor compensation was affected by Defendants' reimbursement rates. Nor did TeamHealth Plaintiffs present any evidence that doctors were leaving the state or that emergency rooms had to close as a result of Defendants' reimbursement rates. This factor also weighs against reprehensibility.

Whether the "defendant has repeatedly engaged in prohibited conduct." 517 U.S. at 576. While TeamHealth Plaintiffs will argue that the jury found Defendants liable for underpaying a large number claims, it cannot be said that Defendants "repeatedly engaged in prohibited conduct." Defendants refused to pay the full amounts of TeamHealth Plaintiffs' invoices because they were unreasonable—and the jury agreed. *See* 11/29/2021 Verdict at Interrogatory Nos. 2-4, 7-9 (refusing to award TeamHealth Plaintiffs' billed charges). The jury thus found that Defendants' decision not to pay TeamHealth Plaintiffs' full billed charges was not "prohibited conduct." And while it is true that the jury found that Defendants underpaid TeamHealth Plaintiffs for the at-issue

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[3] Plaintiffs argued to the jury that Defendants "cut us to the bone," 12/7/2021 Tr. 106:18, and scared the jury with visions of Defendants "gobbling up doctor's practices," such that when someone goes to the ER, Plaintiffs will no longer be able to staff ER doctors, but rather the patient will be "treated by someone that ultimately reports to an insurance executive whose job it is to cut costs." 12/7/2021 Tr. 110:2-10. The Court sustained Defendants' objection to this argument, noting that "[n]one of this is in evidence." 12/7/2021 Tr. 110:14-16.

claims,[4] those claims were reimbursed by consistently applying plan document benefits. *See* 11/10/2021 Tr. 25:24-28:5 (Mr. Haben testified that the allowed amount payable to providers "is defined by the benefit plan" and is not the billed charges); *id*. 33:22-34:2 (Mr. Haben testified that the allowed amount for out-of-network claims is paid based on what is "[d]efined in the benefit plan"); 11/16/2021 Tr. 148:12-18 (Ms. Hare testified that HPN's & SHL's claims processing system is designed to reimburse claims based on plan documents and not full billed charges). In other words, it is not as if each occurrence of declining to pay facially unreasonable invoices entailed an independent moment of *mens rea* by a managerial agent. This factor weighs against reprehensibility, or at least against finding reprehensibility to a significant extent.

Whether the defendant's conduct involved "deliberate false statements, acts of affirmative misconduct, or concealment." 517 U.S. at 579. First, TeamHealth Plaintiffs did not raise, and the jury did not determine, a cause of action for fraud. Second, the Court cannot infer from the verdict any determinations of intentional, deliberate, or affirmative acts to harm TeamHealth Plaintiffs, because imposing liability under the actual causes of action did not entail such findings.

For instance, liability for unjust enrichment lies as long as "retention of the benefit is unjust." Jury Instruction No. 22. The jury was not required to find that Defendants were *aware* of any unjustness, such that the verdict can be deemed to imply intentional misconduct. *Id*. Nor does anything in the instruction regarding breach of an implied contract connote intentional conduct. *See* Jury Instruction No. 26. Rather the Court explained to the jury that "contractual intent is determined by the *objective* meaning of the conduct of the parties under the circumstances," *not* by subjective intent. Jury Instruction No. 29 (emphasis added). Liability under the Unfair Claims Practices Act ("UCPA") required the jury to make an objective finding that Defendants owed money on a claim that they did not satisfy, and a subjective finding that Defendants had subjective awareness that that money was not *paid*. Jury Instructions Nos. 36, 37.

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[4] The jury found that the appropriate reimbursement rate was, on average ~319% of Medicare, compared to the ~760% of Medicare TeamHealth Plaintiffs demanded, on average, for the At-Issue Claims, *see* 12/7/2021 Tr. 81:7-13, 116:19-25; 11/29/2021 Verdict at Interrogatory Nos. 2-4, 7-9, further underscoring the comparative reasonableness of Defendants' reimbursement at, on average, ~164% of Medicare.

But liability under the UCPA does *not* consider whether Defendants subjectively knew its *coverage determination* was incorrect, which is the only evidence of Defendants' conduct TeamHealth Plaintiffs presented. *See, e.g.*, Defs' Rule 50(b) Mot. at II.B.5. The jury instead determined that Defendants' *obligation to pay* the amount claimed "has become reasonably clear" by objective standards. Jury Instruction No. 36.[5] Similarly, to succeed on the claim under the Prompt Pay Act, the jury determined only that Defendants failed to pay a claim the jury deemed payable (Jury Instruction No. 38), not that Defendants were *aware* the claim required payment. Put simply, the causes of action underlying the compensatory damages do not require *mens rea*, so the verdict cannot imply *mens rea*.

Even the jury's imposition of punitive damages does not necessarily imply "deliberate false statements, acts of affirmative misconduct, or concealment." 517 U.S. at 579. The Court's instruction empowered the jury to impose punitive damages for "oppression, fraud, *or malice*," (Jury Instruction No. 39), and the verdict form similarly inquired whether they the jury found any of those three: "Do you find . . . oppression, fraud, or malice in any of the conduct[.]" "Special Verdict Form," filed Nov. 29, 2021, interrogatories 15 and 16. By the Court's instruction, "malice" may entail "conduct that is intended to injure a person ***or*** despicable conduct engaged in with conscious disregard," which in turn "means *knowledge of the probable harmful consequences* of a wrongful act and a willful and deliberate *failure to avoid* these consequences." Jury Instruction No. 39. Thus, the Court may infer from the jury's imposition of punitive damages nothing more than a determination that Defendants' failure to pay the amounts the jury deemed payable was "wrongful" and foreseeably harmful, and that Defendants were indifferent to financial harm that withholding the funds might cause. While it is possible the jury found Defendants culpable of fraud or oppression, it is not necessarily so, and there is no indication whatsoever that the jury did so, as compared to simply malicious. So, the Court cannot infer the jury did.

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[5] As discussed in Defendants' Rule 50(b) Renewed Motion for Judgment as a Matter of Law, the jury's award of compensatory damages at a rate far below what TeamHealth Plaintiffs asserted was the amount owed, and different from the damages estimate either party's expert presented, necessarily means that Defendants' obligation to pay the amount the jury awarded had *not* become reasonably clear. Defs' Rule 50(b) Mot. at II.B.3.

Given the absence of any record that TeamHealth Plaintiffs' harm "was the result of intentional malice, trickery or deceit," *State Farm*, 538 U.S. at 419, this factor also militates against finding Defendants acted with a degree of repressibility "that warrants a substantial punitive damages award." *Gore*, 517 U.S. at 580.

2. Analogous Caselaw Confirms the Court Cannot Impute Sufficient Reprehensibility to Justify this Massive Award

Nevada case law on economic harm supports reducing the punitive damages award. In *Ace Truck v. Kahn*, which involved a pure business transaction, the court found a roughly one-to-one punitive to compensatory damage ratio appropriate. 103 Nev. 503, 511, 746 P.2d 132, 137-38 (1987). *Ace Truck* predates *Bongiovi*'s adoption of the federal guideposts articulated in *Gore*, but as the *Bongiovi* court observed, Nevada's pre-*Gore* standard "varie[d] only slightly from the federal standard" articulated in *Gore*. *Bongiovi*, 122 Nev. at 583, 138 P.3d at 452. *Ace Truck*, therefore, remains persuasive on the permissible amount of punitive damages allowable in business transaction cases.[6]

The Nevada Supreme Court has found larger punitive damages awards appropriate, but only where defendants reprehensibility was *much* higher than that supported by the jury's verdict. In *Evans v. Dean Witter Reynolds*, which supported a punitive damages award of ***2.4*** times compensatory damages, the defendants assisted a fiduciary with looting millions of dollars from the estate of his mentally and physically incompetent beneficiary. 116 Nev. 598, 602-04, 5 P.3d 1043, 1045-47 (2000). The reprehensibility of the *Evans* defendants was two-fold: (1) the particular vulnerability of an incompetent client; and (2) the fiduciary relationship that was violated.

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[6] In unpublished decisions following *Bongiovi*, the Nevada Supreme Court continued to rely on *Ace Truck*'s pronouncement that "a simple business sales transaction in which the plaintiffs accused the defendants of misrepresentation and fraud ... can probably be said to be toward the lower end of the spectrum of malevolence found in punitive damages case." *Ace Truck v. Kahn*, 103 Nev. 503, 511, 746 P.2d 132, 137 (1987), *cited in Exposure Graphics v. Rapid Mounting Display*, No. 54069, 128 Nev. 895, 2012 WL 1080596, at *2 (2012) (concluding that this pre-*Bongiovi* assessment remains good law under the current "reprehensibility" framework). Defendants do not cite *Exposure Graphics* itself as controlling or precedential authority, NRAP 36(c)(3), but merely point out the Supreme Court's continued reliance on the published authority of *Ace Truck*, which has not been abrogated for this purpose.

This case stands in stark contrast to *Evans*. Whereas *Evans* centered on an utterly incompetent and helpless widow bilked of funds on which she relied for sustenance, *id.* at 1045-47), TeamHealth Plaintiffs are private equity backed business-savvy physician-staffing companies who were market driven to maximize their own interests in negotiation with other business entities at arm's length. In fact, this Court's rulings recognize that the parties are equally sophisticated. *See* 10/22/2021 Tr. 65:3-4 ("This is big business against big business."). And TeamHealth Plaintiffs dropped their allegation that there was a "special element of reliance or trust" between the parties such that "Defendants were in a superior or entrusted position of knowledge." *Compare* First Amend. Compl. ¶ 209 *to* Second Amend. Compl. TeamHealth Plaintiffs successfully moved *in limine* to exclude any reference to this allegation. 11/1/2021 Order Granting Plfs' Mot. *in Limine* to Exclude Evidence re Dismissed Claims.

This case also does not involve a fiduciary relationship, which further distinguishes it from *Evans* and emphasizes that this case is unlike the type of consumer-insurance-coverage cases quintessentially contemplated in NRS 42.005(2)(b)'s exception to Nevada's statutory cap on punitive damages. *Id.* ("The limitations on the amount of an award of exemplary or punitive damages prescribed in subsection 1 do not apply to an action brought against: . . . (b) An insurer who acts in bad faith regarding its obligations to provide insurance coverage"). "The duty owed by an insurance company *to an insured* is fiduciary in nature." *Powers v. United Servs. Auto. Ass'n*, 115 Nev. 38, 42, 979 P.2d 1286, 1288 (1999) (emphasis added). "A fiduciary relationship exists when one has the right to expect trust and confidence in the integrity and fidelity of another." *Id.* However, TeamHealth Plaintiffs abandoned any ability to claim that they are Defendants' fiduciaries when they dismissed their allegation that there was "special element of reliance or trust" existing between them. Not only are TeamHealth Plaintiffs not insureds, they also argued at trial that they are in direct competition with Defendants. *See* 12/7/2021 Tr. 110:2-3. It defies logic that a sophisticated commercial entity had the right to expect trust and confidence of an equally sophisticated competitor.

As discussed more fully below, the jury awarded punitive damages that were on average just under *23 times* the amount of compensatory damages. Even *if* TeamHealth Plaintiffs proved

facts satisfactory under the *Evans* standard, which they did not, the punitive damages award is excessive and should be reduced. Because the harm in this case is akin to that in *Ace Truck*, the damages award should be reduced even more.

C. The Extreme Disparity between the Compensatory and Punitive Damages is Unsustainable

The Nevada Supreme Court has held that "awards of punitive damages are generally limited by procedural and substantive due process concerns." *Wyeth*, 126 Nev. At 474–75, 244 P.3d at 784–85, *citing State Farm*, 538 U.S. at 416–17. And "the Fourteenth Amendment's Due Process Clause prohibits punitive damages awards that are grossly excessive or arbitrary." *Id*.; *Bongiovi*, 122 Nev. at 582, 138 P.3d at 451. An important guidepost for recognizing excessiveness is "the ratio of the punitive damages award to the actual harm inflicted on the plaintiff." *Id*.; *see Gore*, 517 U.S. 559.

1. The Ratios Between Compensatory and Punitive Damages are Absurd and Must Be Remitted

Here, the ratios are obscene. The *lowest* ratio is nearly 5:1, where the jury awarded $1,007,374.49 in compensatory damages to TeamHealth Plaintiff Fremont Emergency Services against Defendant Sierra Health and Life Insurance Company, and $5 million in punitive damages for the same plaintiff-defendant pairing. *Compare* 11/29/21 Special Verdict Form at 3, *with* 12/07/21 Special Verdict Form at 3. At the high end, however, the punitive damages award shot up to *14,210 times* compensatory damages—representing $281.49 in compensatory damages and $4 million in punitive damages to TeamHealth Plaintiff Ruby Crest against Defendant HPN. *Compare* 11/29/21 Special Verdict Form, at 4, *with* 12/07/21 Special Verdict Form, at 3. Given the minimal evidence introduced at trial related to defendant HPN, this outcome shocks the conscience. Overall, the punitive damages awards against all Defendants ($60 million) exceeded the compensatory awards ($2.65 million) by nearly 23 times.[7]

[7] As noted in the Motion for New Trial, opposing counsels' misconduct plagued the lability and punitive damages verdicts. Mot. for New Trial re Trial Errors at Sections I.A.2-3, I.B.1-2. In particular, TeamHealth Plaintiffs conditioned the jury into believing this case was about the quality of care regarding emergency medicine services and that Defendants were underpaying claims that saved lives. *Id*. at Sections I.A.2-3. Opposing counsel then parlayed that improper conditioning to inflame the jury's passions when arguing that the jury should award massive punitive damages.

The U.S. Supreme Court has not set a fixed ratio limiting punitive damages. *State Farm*, 538 U.S. at 425 ("[T]here are no rigid benchmarks that a punitive damages award may not surpass . . . ."). It has noted, however, that ***"few awards exceeding a single-digit ratio between punitive and compensatory damages ... will satisfy due process."*** *Id.* (emphasis added).

But punitive damages do not normally, or may not always constitutionally, exceed compensatory damages. As discussed *supra*, Section I.B.1., in cases of purely economic harm, the *high* end of such a ratio should be closer to 1-to-1. *Ace Truck*, 103 Nev. at 512, 746 P.2d at 138; *Bongiovi*, 122 Nev. At 583, 138 P.3d at 452. And *Bongiovi* itself involved a 1:1 ratio, which the Nevada Supreme Court considered substantial and justified only because "Bongiovi's conduct was reprehensible to a large degree because of the egregiousness and offensiveness of his statements about Sullivan" and because "Sullivan suffered *great emotional harm* and lost business." *Id.* Even under the extreme facts of the *Evans* case above, an appropriate ratio would be only 2.5 to one.

And when, as here, the compensatory damages here are substantial, the Supreme Court has noted that "a lesser ratio, perhaps only equal to compensatory damages, can reach the outermost limit of the due process guarantee." *State Farm*, 538 U.S. at 425.

This is not an exceptional case where the compensatory award itself was small in absolute terms or the injury was hard to detect. *See Gore*, 517 U.S. at 581. Indeed, the jury's compensatory awards were extremely precise because the economic injury consisted solely of the difference between what Defendants had already reimbursed and what the jury determined to be a reasonable rate of reimbursement; TeamHealth Plaintiffs disclaimed consequential damages. In addition, the awards taken together were substantial, totaling more than $2.65 million dollars. Even assuming that the smallest compensatory awards on their own might permit a higher ratio than 1:1, even up to the presumptive outer bound of 9:1, there is *no* constitutional justification for an overall

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See id. at Sections I.B.1-2; *id*. at __ (arguing that "if you [the jury] talk with a whisper, I'm sorry, you have wasted a month and a half of your lives" (quoting 12/7/2021 Tr. 107:14-15)). As such, TeamHealth Plaintiffs were able to obtain an unconstitutionally disproportional punitive damages award through misconduct tactics that inflamed the passions of the jury.

punitives-to-compensatory ratio of almost 23:1. Even an award equal to compensatory damages, as in *Bongiovi* or *Ace Truck*, or perhaps as much as 2.5 times, as in *Evans*, would meet or even exceed the constitutional limit.

2. The Jury's Verdict Does Not Reflect the Requisite Individualized Analysis and is Thus Unreliable

Jurors are charged to thoughtfully, carefully and impartially consider the evidence before deciding upon a verdict. NEVADA JURY INSTRUCTIONS—CIVIL (2011 ed.) Instruction No. 11.01 ("Whatever your verdict is, it must be the product of a careful and impartial consideration of all the evidence in the case under the rules of law as given you by the court.").

In stark contrast to the deliberation taken in determining the compensatory award, the jury awarded punitive damages by repeatedly using the same round numbers. 12/7/21 Special Verdict Form at 2; 11/23/21 Special Verdict Form. This is striking because the evidence pertaining to each TeamHealth Plaintiff-Defendant pairing was vastly different. That is, the conduct of each Defendant differed vis-à-vis each TeamHealth Plaintiff and the harms of each TeamHealth Plaintiff varied. To be sure, of the 11,563 at-issue claims, UHS was responsible for 3,803 and HPN was responsible for 119. *See* PX 473. However, the jury awarded $4,500,000 in punitive damages to each TeamHealth Plaintiff against UHS and $4,000,000 in punitive damages to each TeamHealth Plaintiff against HPN. 12/7/21 Special Verdict Form at 2. In other words, while HPN was only responsible for 1% of the claims at-issue, it is responsible for 20% of the punitive damages award. *See* PX 473; 12/7/21 Special Verdict Form at 2. This is absurd. Moreover, of the 119 at-issue claims that HPN is responsible for, 109 were asserted by Fremont, 6 were asserted by Team Physicians, and 4 were asserted by Ruby Crest. PX 473. It shocks the conscious that HPN's conduct can be equally reprehensible vis-à-vis each TeamHealth Plaintiff. Similarly, even though Fremont asserted 10,387 of the at-issue claims, *i.e.*, ~90% of the at-issue claims, each TeamHealth Plaintiff was awarded the same punitive damages amount. PX 473; 12/7/21 Special Verdict Form at 2. It shocks the conscious that the jury could find that Defendants' conduct vis-à-vis Fremont was equally reprehensible to Defendants' conduct vis-à-vis Team Physicians and/or

Ruby Crest. Thus, the jury did not thoughtfully, carefully and impartially consider the evidence before deciding the punitive damages award and it is unreliable.

D. In Light of the Penalty Interest under the Prompt Pay Act, No Further Punitive Damages Are Appropriate

TeamHealth Plaintiffs have not demonstrated that Defendants would have been subject to any civil penalties—at least no penalties that are not already reflected in the compensatory damage award. For instance, although the Prompt Pay Act provides for heightened interest on unpaid claims—6% above the prime rate, *e.g.*, NRS 689B.255(1), as opposed to 2% above prime for ordinary prejudgment interest, NRS 17.130(2), NRS 99.040(1)(a)—those penalties are already reflected in the compensatory award.

Indeed, for that very reason, the judgment—with Prompt Pay Act penalty interest on the compensatory award—already reflects a punitive element. *Cf. Countrywide Home Loans, Inc. v. Thitchener*, 124 Nev. 725, 735 n.14, 192 P.3d 243, 250 n.14 (2008). TeamHealth Plaintiffs in this instance have to choose between the statutory penalty and punitive damages. An additional award of punitive damages for precisely the same conduct as that which gave rise to Prompt Pay Act liability—paying an unreasonably low reimbursement rate—is improper.

Alternatively, even if punitive damages may be combined with Prompt Pay Act interest, the award here is still grossly excessive. Looking at the Prompt Pay Act interest as an appropriate comparator, the *total* amount ($779,361.97) is just 29% of the compensatory award. That, of course, includes all of the interest, not just the 4% difference between ordinary judgment interest and the "penalty" interest under the Prompt Pay Act. This only confirms the analysis above: that a punitives award *equal* to compensatory damages—many times more than the comparable Prompt Pay Act penalty—scrapes the outer constitutional limit.

E. The No Surprises Act Replaces Jury Awards and Punitive Damages with a Regulatory Mechanism

Also significant is the Legislature's decision via the No Surprises Act (and Congress's similar effort at the federal level) to take the question of setting reimbursement rates for emergency medical services away from juries altogether. As of January 1, 2022, rather than allowing those disputes to proceed in a forum where claims for punitive damages or other penalties, may be

engineered, Assembly Bill 469 creates an expedited regulatory process: unreconciled differences proceed to binding arbitration. NRS 439B.160; NRS 439B.751(2); NRS 439.754; *see also* H.R. 133, § 103 (effective January 1, 2022).

Far from authorizing astronomical civil penalties for an insurer's alleged underpayment of a claim for emergency services, the Legislature has streamlined the resolution of rate-of-payment disputes and removed the threat of large punitive damages awards altogether. *See* NRS 439B.754. In this circumstance, the jury's award of $60 million in punitive damages is wildly incomparable to any civil penalty the Legislature did or would now authorize.

The purpose of punitive damages is to punish and deter a defendant's culpable conduct. *Bongiovi*, 122 Nev. at 580, 138 P.3d at 450. The enactment of the No Surprises Act may impact how insurers consider reimbursement rates, so the conduct at issue here—the way Defendants set their reimbursement rates—has already been addressed. Punitive damages awards are also intended to demonstrate to defendants and others that particular conduct is not acceptable and will not be tolerated. *Id.* But again, Defendants' future conduct has already been altered by the No Surprise Act. Thus, any additional deterrence is unnecessary based on the regulatory scheme set forth by the No Surprise Act. The Court should thus vacate the punitive damages award in its entirety.[8]

[8] As discussed *supra*, if the Court disagrees that punitive damages are entirely inappropriate, the Court should remit the award to an amount that comports with NRS 40.005 and both federal and state Due Process requirements. *See Ace Truck*, 103 Nev. at 511, 746 P.3d at 138 (remitting punitive damages award as the amount was disproportionate); *Albert H. Wohlers*, 114 Nev. at 1268, 969 P.2d at 962 (remitting award after concluding the punitives damage award was clearly disproportionate to the degree of reprehensibility); *Kellar v. Brown*, 101 Nev. 273, 274, 701 P. 2d 359, 359-60 (1985) (ordering remittitur because punitive award of more than five times the compensatory damages was disproportionate and unnecessary to deter future wrongdoing); *Mendez-Matos v. Municipality of Guaynabo*, 557 F.3d 36, 56 (1st Cir. 2009) (affirming district court's remittitur of punitive damages award because punitive damages award grossly exceeded what was necessary to punish and deter defendant's conduct).

II.

THE JUDGMENT MUST NOT BE READ TO IMPOSE PROMPT PAY ACT INTEREST ON TOP OF POST-JUDGMENT INTEREST

Once a judgment is entered, the principal amount is fixed for purposes of post-judgment interest.[9] NRS 17.130(2) does not authorize compound interest. *Torres v. Goodyear Tire & Rubber Co.*, 130 Nev. 22, 24, 317 P.3d 828, 829 (2014). Here, TeamHealth Plaintiffs' judgment includes a fixed amount of Prompt Pay Act interest. That interest, incorporated into the judgment, is fixed for purposes of calculating ordinary post-judgment interest. To allow plaintiffs to *continue* to seek Prompt Pay Act interest on top of post-judgment interest would impermissibly authorize compound interest. "As a general rule, compound interest is not favored by the law and is generally allowed *only* in the presence of a statute or an agreement between the parties allowing for compound interest." *Id.* Neither is present here. There is no statute authorizing TeamHealth Plaintiffs to recover compound interest, and Defendants have not agreed to permit TeamHealth Plaintiffs to recover compound interest. Accordingly, the Court should prohibit TeamHealth Plaintiffs from incurring any additional post-judgment interest under the Prompt Pay Act.

CONCLUSION

For the foregoing reasons, this Court should eliminate the award of punitive damages. Alternatively, it should reduce the ratio of punitive damages to be equal to the compensatory damages.

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[9] Of course, if the judgment is partially satisfied, post-judgment interest runs only on the unsatisfied amount. NRS 17.130(1).

Dated this 6th day of April, 2022.

/s/ Abraham G. Smith

Daniel F. Polsenberg, Esq.
Joel D. Henriod, Esq.
Abraham G. Smith, Esq.
Lewis Roca Rothgerber Christie LLP
3993 Howard Hughes Parkway
Suite 600
Las Vegas, Nevada 89169-5996
Telephone: (702) 949-8200

D. Lee Roberts, Jr., Esq.
Colby L. Balkenbush, Esq.
Brittany M. Llewellyn, Esq.
Phillip N. Smith, Jr., Esq.
Marjan Hajimirzaee, Esq.
WEINBERG, WHEELER, HUDGINS, GUNN & DIAL, LLC
6385 South Rainbow Blvd.
Suite 400
Las Vegas, Nevada 89118

Attorneys for Defendants

Dimitri D. Portnoi, Esq.(*Pro Hac Vice*)
Jason A. Orr, Esq. (*Pro Hac Vice)*
Adam G. Levine, Esq. *(Pro Hac Vice)*
Hannah Dunham, Esq. *(Pro Hac Vice)*
Nadia L. Farjood, Esq. (*Pro Hac Vice*)
O'Melveny & Myers LLP
400 S. Hope St., 18th Floor
Los Angeles, CA 90071

K. Lee Blalack, II, Esq.(*Pro Hac Vice)*
Jeffrey E. Gordon, Esq. *(Pro Hac Vice)*
Kevin D. Feder, Esq. *(Pro Hac Vice)*
Jason Yan, Esq. *(Pro Hac Vice)*
O'Melveny & Myers LLP
1625 Eye St. NW
Washington, DC 20006

Paul J. Wooten, Esq. *(Pro Hac Vice)*
Philip E. Legendy *(Pro Hac Vice)*
O'Melveny & Myers LLP
Times Square Tower, Seven Times Square
New York, NY 10036

CERTIFICATE OF SERVICE

I hereby certify that on the 6th day of April, 2022, a true and correct copy of the foregoing **"DEFENDANTS' MOTION FOR REMITTITUR AND TO ALTER OR AMEND THE JUDGMENT"** was electronically filed and served on counsel through the Court's electronic service system pursuant to Administrative Order 14-2 and N.E.F.C.R. 9, via the electronic mail addresses noted below, unless service by another method is stated or noted:

Pat Lundvall, Esq.
Kristen T. Gallagher, Esq.
Amanda M. Perach, Esq.
McDonald Carano LLP
2300 W. Sahara Ave., Suite 1200
Las Vegas, Nevada 89102
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Judge David Wall, Special Master
Attention: Mara Satterthwaite & Michelle Samaniego
JAMS
3800 Howard Hughes Parkway
11th Floor
Las Vegas, NV 89123
msatterthwaite@jamsadr.come
msamaniego@jamsadr.com

Justin C. Fineberg
Martin B. Goldberg
Rachel H. LeBlanc
Jonathan E. Feuer
Lash & Goldberg LLP
Weston Corporate Centre I
2500 Weston Road Suite 220
Fort Lauderdale, Florida 33331
jfineberg@lashgoldberg.com
mgoldberg@lashgoldberg.com
rleblanc@lashgoldberg.com
jfeuer@lashgoldberg.com

Joseph Y. Ahmad (admitted *pro hac vice*)
John Zavitsanos (admitted *pro hac vice*)
Jason S. McManis (admitted *pro hac vice*)
Michael Killingsworth (admitted *pro hac vice*)
Louis Liao (admitted *pro hac vice)*
Jane L. Robinson (admitted *pro hac vice*)
P. Kevin Leyendecker (admitted *pro hac vice*)
Ahmad, Zavitsanos, Anaipakos, Alavi & Mensing,
1221 McKinney Street, Suite 2500
Houston, Texas 77010
Telephone: 713-600-4901
joeahmad@azalaw.com;jzavitsanos@azalaw.com
jmcmanis@azalaw.com;mkillingsworth@azalaw.com
lliao@azalaw.com; jrobinson@azalaw.com
kleyendecker@azalaw.com

Attorneys for Plaintiffs

/s/ Cynthia Kelley
An employee of LEWIS ROCA ROTHGERBER CHRISTIE