Case Nos. 85525 & 85656

# In the Supreme Court of Nevada

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| UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTH CARE SERVICES, INC.; UMR, INC.; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.; and HEALTH PLAN OF NEVADA, INC.,<br>Appellants,<br>*vs.*<br>FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C.; and CRUM STEFANKO AND JONES, LTD.,<br>Respondents. | Case No. 85525 |
| UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTH CARE SERVICES, INC.; UMR, INC.; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.; and HEALTH PLAN OF NEVADA, INC.,<br>Petitioners,<br>*vs.*<br>THE EIGHTH JUDICIAL DISTRICT COURT of the State of Nevada, in and for the County of Clark; and the Honorable NANCY L. ALLF, District Judge,<br>Respondents,<br>*vs.*<br>FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C.; and CRUM STEFANKO AND JONES, LTD.,<br>Real Parties in Interest. | Case No. 85656 |



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K. LEE BLALACK II
(*pro hac vice*)
JONATHAN D. HACKER (*pro hac vice forthcoming*)
O'MELVENY & MYERS LLP
1625 Eye Street, N.W.
Washington, D.C. 20006

DANIEL F. POLSENBERG (SBN 2376)
JOEL D. HENRIOD (SBN 8492)
ABRAHAM G. SMITH (SBN 13,250)
KORY J. KOERPERICH (SBN 14,559)
LEWIS ROCA ROTHGERBER CHRISTIE LLP
3993 Howard Hughes Pkwy., Ste. 600
Las Vegas, Nevada 89169

D. LEE ROBERTS (SBN 8877)
COLBY L. BALKENBUSH (SBN 13,066)
WEINBERG, WHEELER, HUDGINS, GUNN & DIAL, LLC
6385 South Rainbow Blvd., Ste. 400
Las Vegas, Nevada 89118

*Attorneys for Appellants/Petitioners*

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## CERTIFICATE OF SERVICE

I certify that on April 18, 2023, I submitted the foregoing appendix for filing *via* the Court's eFlex electronic filing system.

Electronic notification will be sent to the following:

Pat Lundvall
Kristen T. Gallagher
Amanda M. Perach
McDONALD CARANO LLP
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102

*Attorneys for Respondents (case no. 85525)/Real Parties in Interest (case no. 85656)*

Richard I. Dreitzer
FENNEMORE CRAIG, PC
9275 W. Russell Road, Suite 240
Las Vegas, Nevada 89148

*Attorneys for Real Parties in Interest (case no. 85656)*

Dennis L. Kennedy
Sarah E. Harmon
BAILEY KENNEDY
8984 Spanish Ridge Avenue
Las Vegas, Nevada 89148

*Attorneys for Respondents (case no. 85525)*

Constance. L. Akridge
Sydney R. Gambee
HOLLAND & HART LLP
9555 Hillwood Drive, Second Floor
Las Vegas, Nevada 89134

*Attorneys for Amicus Curiae (case no. 85656)*

I further certify that I served a copy of this document by mailing a true and correct copy thereof, postage prepaid, at Las Vegas, Nevada, addressed as follows:

The Honorable Nancy L. Allf
DISTRICT COURT JUDGE – DEPT. 27
200 Lewis Avenue
Las Vegas, Nevada 89155

*Respondent (case no. 85656)*

Joseph Y. Ahmad
John Zavitsanos
Jason S. McManis
Michael Killingsworth
Louis Liao
Jane L. Robinson
Patrick K. Leyendecker
AHMAD, ZAVITSANOS, & MENSING, PLLC
1221 McKinney Street, Suite 2500
Houston, Texas 77010

Justin C. Fineberg
Martin B. Goldberg
Rachel H. LeBlanc
Jonathan E. Feuer
Jonathan E. Siegelaub
David R. Ruffner
Emily L. Pincow
Ashley Singrossi
LASH & GOLDBERG LLP
Weston Corporate Centre I
2500 Weston Road Suite 220
Fort Lauderdale, Florida 33331

*Attorneys for Respondents (case no. 85525)/Real Parties in Interest (case no. 85656)*

*/s/ Jessie M. Helm*
An Employee of Lewis Roca Rothgerber Christie LLP

submitted by you;

b) Patient first name, last name and middle name and/or initials;

c) Defendants' member and/or subscriber identification number;

d) Billed charges and/or total amount billed on the Claim;

e) Provider name; and

f) Provider Tax I.D. number.

**RESPONSE:**

*See* FESM00344. The Health Care Providers' claims are continuing and will be updated on a regular basis.

97. Provider Tax I.D. number for all documents related to your determination and/or calculation of the billed charges for the Claims asserted in the First Amended Complaint.

**RESPONSE:**

Objection. This request is vague, ambiguous and unintelligible. For these reasons, the Health Care Providers decline to respond. The Health Care Providers will reconsider their response to this request upon further clarification of the documents sought.

98. All documents comparing your billed charges for emergency medical services to the reimbursement amounts set by the Centers for Medicare and Medicaid Services for reimbursement of such services for every year since July 1, 2017.

**RESPONSE:**

Objection. The request seeks information that is not relevant and proportional to the needs of the case as information concerning reimbursement amounts set by the Centers for Medicare and Medicaid Services has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses. In addition, this request seeks documents not in the Health Care Providers' possession because the particularities of this request would require the Health Care Providers to create a document containing the requested information. By way of further objection, the request is designed for an

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

improper purpose to annoy, embarrass and oppress. Subject to and without waiving the foregoing objections, the Health Care Providers decline to respond to this request.

99. All documents relating to the comparison of your billed charges for emergency medical services to the reimbursement rates you have agreed to accept by contract from Payers other than Defendants from July 1, 2017 to present.

**RESPONSE:**

Objection. The request seeks information that is not relevant and proportional to the needs of the case as information concerning reimbursement rates agreed to pursuant to a contract with other Payers has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses. In addition, this request seeks documents not in the Health Care Providers' possession because the particularities of this request would require the Health Care Providers to create a document containing the requested information. By way of further objection, the request is designed for an improper purpose to annoy, embarrass and oppress. Subject to and without waiving the foregoing objections, the Health Care Providers decline to respond to this request.

100. All documents relating to payments that you have received from any source with respect to the Claims asserted in the First Amended Complaint, including, but not limited to, payments received from patients, Defendants and/or other Payers (such as government payers, commercial payers, managed care organizations, and Medicare Advantage plans).

**RESPONSE:**

Objection. The request seeks information that is not relevant and proportional to the needs of the case as information concerning payments received on the allowed amount of each of the Claims has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses. In addition, this request is overly broad and unduly burdensome. Subject to and without waiving the foregoing objections, the Health Care Providers decline to respond to this request.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

101. All documents that you provided to your patients relating to patient financial responsibility for out-of-network emergency medical services for all of the Claims.

**RESPONSE:**

Objection. The request is vague and ambiguous as to the terms "patient financial responsibility," seeks information that is not relevant and proportional to the needs of the case as the instance of an such documents, if any, has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; is a request designed to unreasonably further delay these proceedings; is designed for an improper purpose to annoy, embarrass and oppress; seeks information equally in the possession of United; is overly broad and unduly burdensome in that it seeks "all" documents; and violates Nevada law by its request for information that may already be in United's possession. *See e.g.* NRS 683A.0879, 689A.410, 689B.255, 689C.485, 695C.185, NAC 686A.675. By way of further objection, whether the Health Care Providers issued such documents will not support or refute any of their claims or United's affirmative defenses. For these reasons, the Health Care Providers decline to respond to the request as currently framed.

102. All documents that you provided to any of your patients from July 1, 2017 to present related to patient financial responsibility for out-of-network emergency medical services.

**RESPONSE:**

Objection. The request is duplicative (RFP No. 101) vague and ambiguous as to the terms "patient financial responsibility," seeks information that is not relevant and proportional to the needs of the case as the instance of an such documents, if any, has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; is a request designed to unreasonably further delay these proceedings; is designed for an improper purpose to annoy, embarrass and oppress; seeks information equally in the possession of United; is overly broad and unduly burdensome in that it seeks "all" documents; and violates Nevada law by its request for information that may already



McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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be in United's possession. *See e.g.* NRS 683A.0879, 689A.410, 689B.255, 689C.485, 695C.185, NAC 686A.675. By way of further objection, whether the Health Care Providers issued such documents will not support or refute any of their claims or United's affirmative defenses. For these reasons, the Health Care Providers decline to respond to the request.

103. All documents that you provided to your patients related to actual or potential responsibility to pay you the difference between your billed charges for emergency medical services and the amounts reimbursed by Defendants related to the Claims.

**RESPONSE:**

Objection. The request is vague and ambiguous as to the term "actual or potential responsibility to pay"; seeks information that is not relevant and proportional to the needs of the case as the Health Care Providers' billing practices, if any, identified above have no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; is a request designed to unreasonably further delay these proceedings; is designed for an improper purpose to annoy, embarrass and oppress; is overly broad and unduly burdensome in that it seeks "all" documents." By way of further objection, whether the Health Care Providers bill patients for outstanding amounts due and owing, will not support or refute any of their claims or United's affirmative defenses; and the request seeks information not within the Health Care Providers' possession, custody or control. For these reasons, the Health Care Providers decline to respond to the request.

104. All documents that you provided to your patients related to actual or potential responsibility to pay you the difference between your billed charges for emergency medical services and the amounts reimbursed by Commercial Payers from July 1, 2017 to present.

**RESPONSE:**

Objection. The request is vague and ambiguous as to the term "actual or potential responsibility to pay"; seeks information that is not relevant and proportional to the needs of the case as the Health Care Providers' billing practices, if any, identified above have no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract,

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; seeks information unrelated to United and therefore is not relevant to the claims and defenses at issue in the litigation; is a request designed to unreasonably further delay these proceedings; is designed for an improper purpose to annoy, embarrass and oppress; is overly broad and unduly burdensome in that it seeks "all" documents." By way of further objection, whether the Health Care Providers bill patients for outstanding amounts due and owing, will not support or refute any of their claims or United's affirmative defenses; and the request seeks information not within the Health Care Providers' possession, custody or control. For these reasons, the Health Care Providers decline to respond to the request.

105. All assignment of benefits forms relating to the Claims asserted in your First Amended Complaint.

**RESPONSE:**

Objection. The request is vague and ambiguous as to the terms "assignment of benefits forms," seeks information that is not relevant and proportional to the needs of the case as the instance of an such documents, if any, has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; is designed for an improper purpose to annoy, embarrass and oppress; seeks information already in the possession of United; seeks information not in the Health Care Providers' possession because those are generally issued and retained by the hospital; is overly broad and unduly burdensome in that it seeks "all" documents; is a request designed to unreasonably further delay these proceedings; and violates Nevada law by its request for information that may already be in United's possession. *See e.g.* NRS 683A.0879, 689A.410, 689B.255, 689C.485, 695C.185, NAC 686A.675. By way of further objection, whether the Health Care Providers issued such documents will not support or refute any of their claims or United's affirmative defenses. For these reasons, the Health Care Providers decline to respond to the request.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

106. All documents which reflect any and all internal analysis that you performed, or which were performed on your behalf, regarding payment rates typically exchanged in the Nevada market, from July 1, 2017.

**RESPONSE:**

Objection. The request is vague and ambiguous with respect to the phrases "internal analysis" and "payment rates typically exchanged in the Nevada market." By way of further objection, the request fails to identify what market and what payment rates to which it is referring. Subject to and without waiving the foregoing objections, the Health Care Providers respond as follows: Non-privileged responsive documents, if any, will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time.

107. All documents, including but not limited to contracts, showing services which any vendors provided you related to billing or submitting claims, reimbursement, collections, determination of the value of services, the setting of Charge Description Master pricing and/or billed charges from July 1, 2017 to present.

**RESPONSE:**

Objection. The request is vague and ambiguous with respect to the phrases "submitting claims" and "determination of the value of services". In addition, the request is irrelevant and not proportional to the needs of the case considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit as the services provided by vendors have no bearing on the claims at issue in this litigation. Subject to and without waiving the foregoing objections, the Health Care Providers respond as follows: Non-privileged responsive documents will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

108. All contracts, arrangements and/or agreements between you and Team Health, Inc., that were in force anytime July 1, 2017 to the present which relate to:

a) Reimbursements for emergency medical claims;

b) Pricing for emergency medical claims;

c) The Claims in dispute in this lawsuit;

d) Defendants.

**RESPONSE:**

Objection. The request seeks information that is not relevant and proportional to the needs of the case as the instance of an such documents, if any, has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; is a request designed to unreasonably further delay these proceedings; is designed for an improper purpose to annoy, embarrass and oppress; is overly broad and unduly burdensome in that it seeks "all" documents. By way of further objection, TeamHealth is not a party to this lawsuit and documents regarding any relationship between the Health Care Providers and TeamHealth do not have any bearing on the dispute at issue in this action which involves the appropriateness (or lack thereof) of the rates of reimbursement which United paid the at-issue claims; the existence or absence of the requested documents will not support or refute any of their claims or United's affirmative defenses. For these reasons, the Health Care Providers decline to respond to the request.

109. All contracts and/or agreements between you and any reimbursement claims specialists or other business entity that were in force anytime from July 1, 2017 to the present which relate to:

a) Reimbursement for emergency medical claims;

b) Pricing for emergency medical claims;

c) The Claims in dispute in this lawsuit; and

d) Defendants.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

**RESPONSE:**

Objection. The request seeks information that is not relevant and proportional to the needs of the case as the instance of an such documents, if any, has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; is a request designed to unreasonably further delay these proceedings; is designed for an improper purpose to annoy, embarrass and oppress; is overly broad and unduly burdensome in that it seeks "all" documents. By way of further objection, whether the existence or absence of the requested documents will not support or refute any of their claims or United's affirmative defenses. Subject to and without waiving the foregoing objections, Non-privileged responsive documents, if any, will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time.

110. All documents reflecting communications between you and Team Health regarding reimbursement for emergency medical claims from July 1, 2017 to the present.

**RESPONSE:**

Objection. The request potentially seeks information protected by the attorney-client privilege and work product doctrine; seeks information that is not relevant and proportional to the needs of the case as the instance of an such documents, if any, has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; is a request designed to unreasonably further delay these proceedings; is designed for an improper purpose to annoy, embarrass and oppress; is overly broad and unduly burdensome in that it seeks "all" documents. Subject to and without waiving the foregoing objections, the Health Care Providers respond as follows: Non-privileged responsive documents will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

111. All documents reflecting communications between you and any reimbursement claims specialists or other business entity regarding reimbursement for emergency medical claims from July 1, 2017 to the present.

**RESPONSE:**

*See* Response to RFP No. 109.

112. All documents reflecting communications between you and Team Health regarding pricing for emergency medical claims from July 1, 2017 to the present.

**RESPONSE:**

Objection. The request is vague and ambiguous as to the term "pricing"; potentially seeks information protected by the attorney-client privilege and work product doctrine; seeks information that is not relevant and proportional to the needs of the case; is not limited to the claims at issue in this case; is not limited to communications specific to United; is a request designed to unreasonably further delay these proceedings; is overly broad and unduly burdensome in that it seeks "all" documents. Subject to and without waiving the foregoing objections, Non-privileged responsive documents will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time.

113. All documents reflecting communications between you and any reimbursement claims specialist or other business entity regarding pricing for emergency medical claims from July 1, 2017 to the present.

**RESPONSE:**

*See* Response to RFP No. 109.

114. All documents reflecting communications between you and Team Health regarding any of the Claims from July 1, 2017 to the present.

**RESPONSE:**

Objection. The request potentially seeks information protected by the attorney-client privilege and work product doctrine; seeks information that is not relevant and proportional to the needs of the case; is overly broad and unduly burdensome in that it seeks "all" documents. Subject

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

to and without waiving the foregoing objections, the Health Care Providers respond as follows: Non-privileged responsive documents will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time.

115. All documents reflecting communications between you and any reimbursement claims specialist or other business entity regarding any of the Claims from July 1, 2017 to the present.

**RESPONSE:**

*See* Response to RFP No. 109.

116. All documents reflecting communications between you and Team Health regarding the Claims from July 1, 2017 to the present.

**RESPONSE:**

Objection. The request potentially seeks information protected by the attorney-client privilege and work product doctrine; seeks information that is not relevant and proportional to the needs of the case; is overly broad and unduly burdensome in that it seeks "all" documents. Subject to and without waiving the foregoing objections, the Health Care Providers respond as follows: Non-privileged responsive documents will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time.

117. All documents reflecting communications between you and any reimbursement claims specialist or other business entity regarding Defendants from July 1, 2017 to the present.

**RESPONSE:**

*See* Response to RFP No. 109.

118. All documents, including but not limited to contracts, showing services which Team Health provided to you related to billing or submitting claims, reimbursement, collections, determination of the value of services, the setting of Charge Description Master pricing and/or billed charges from July 1, 2017 to the present.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

**RESPONSE:**

Objection. This request seeks documents that are confidential; seeks information that is not proportional to the needs of the case as "documents, including but not limited to contracts, showing services which Team Health provided" has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; and is designed for an improper purpose to annoy, embarrass and oppress. Subject to and without waiving the foregoing objections, Non-privileged responsive documents will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time.

119. All documents, including but not limited to contracts, showing services which any reimbursement claims specialist or other business entity provided to you related to billing or submitting claims, reimbursement, collections, determination of the value of services, the setting of Charge Description Master pricing and/or billed charges from July 1, 2017 to the present.

**RESPONSE:**

Objection. This request seeks documents that are confidential; seeks information that is not proportional to the needs of the case as "documents, including but not limited to contracts, showing services which Team Health provided" has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; and is designed for an improper purpose to annoy, embarrass and oppress. Subject to and without waiving the foregoing objections, the Health Care Providers respond as follows: Non-privileged responsive documents, if any, will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time.

120. All documents from Team Health, which provide instructions, directives or guidance for maximizing reimbursements for out-of-network claims from July 1, 2017 to the present.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

**RESPONSE:**

Objection. The request is vague and ambiguous as to the phrase "maximizing reimbursements" and is overly broad as the request is not limited to the claims at issue in this case. Subject to and without waiving the foregoing objections, the Health Care Providers respond as follows: Non-privileged responsive documents, if any, will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time.

121. All documents from any business entity which provides instructions, directives, or guidance for maximizing reimbursements for out-of-network claims from July 1, 2017 to the present.

**RESPONSE:**

Objection. The request is vague and ambiguous as to the phrase "maximizing reimbursements" and is overly broad as the request is not limited to the claims at issue in this case. Subject to and without waiving the foregoing objections, the Health Care Providers respond as follows: Non-privileged responsive documents, if any, will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time.

122. All documents reflecting communications between you and Team Health, from July 1, 2017 to the present, regarding instructions, directives or guidance which relate to:

a) Reimbursement for emergency medical claims;

b) Pricing for emergency medical claims;

c) The Claims in dispute in this lawsuit; and

d) Defendants.

**RESPONSE:**

Objection. The request is overly broad and unduly burdensome. By way of further objection, the request is not limited to the claims at issue in this case. Additionally, the request potentially seeks documents protected by the attorney-client privilege and work product doctrine. Subject to and without waiving the foregoing objections, the Health Care Providers respond as

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966



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follows: Non-privileged responsive documents, if any, will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time.

123. All documents reflecting communications between any you and any business entity, from July 1, 2017 to the present, regarding instructions, directives or guidance which relate to:

a) Reimbursement for emergency medical claims;

b) Pricing for emergency medical claims;

c) The Claims in dispute in this lawsuit; and

d) Defendants.

**RESPONSE:**

Objection. The request is overly broad and unduly burdensome. By way of further objection, the request is not limited to the claims at issue in this case. Additionally, the request potentially seeks documents protected by the attorney-client privilege and work product doctrine. In addition, to the extent this request seeks communications with Defendants, these documents are already in the possession of Defendants. Subject to and without waiving the foregoing objections, the Health Care Providers respond as follows: Non-privileged responsive documents, if any, will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time.

124. All documents concerning compensation, incentives, or renumeration of any sort paid to/credited to you—or anyone with a direct or indirect ownership or control of you, including joint ventures—by hospitals/facilities or their affiliated entities, including joint ventures, where the emergency medical services in question were rendered, whether on a per claim basis, in the aggregate, or by any other means.

**RESPONSE:**

Objection. The request is vague and ambiguous as to the terms "compensation," "incentives" or "renumeration of any sort"; seeks information that is not relevant and proportional

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966



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to the needs of the case as the instance of an such documents, if any, has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; is a request designed to unreasonably further delay these proceedings; is designed for an improper purpose to annoy, embarrass and oppress; is overly broad and unduly burdensome in that it seeks "all" documents. By way of further objection, whether the existence or absence of the requested documents will not support or refute any of the Health Care Providers' claims or United's affirmative defenses. For these reasons, the Health Care Providers decline to respond to the request.

125. All documents concerning compensation, incentives, or renumeration of any sort paid by/credited by you—or on your behalf by anyone—to hospitals/facilities or their affiliated entities, including joint ventures, where the emergency medical services in question were rendered, whether on a per claim basis, in the aggregate, or by any other means.

**RESPONSE:**

Objection. The request is vague and ambiguous as to the terms "compensation," "incentives" or "renumeration of any sort"; seeks information that is not relevant and proportional to the needs of the case as the instance of an such documents, if any, has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; is a request designed to unreasonably further delay these proceedings; is designed for an improper purpose to annoy, embarrass and oppress; is overly broad and unduly burdensome in that it seeks "all" documents. By way of further objection, whether the existence or absence of the requested documents will not support or refute any of the Health Care Providers' claims or United's affirmative defenses. For these reasons, the Health Care Providers decline to respond to the request.

126. All documents relating to presentations and/or proposals you have made to the facilities where services in question were rendered regarding your emergency medical services.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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**RESPONSE:**

Objection. The request is vague and ambiguous as to the terms "presentations" and "proposals"; seeks information that is not relevant and proportional to the needs of the case as the instance of an such documents, if any, has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; is a request designed to unreasonably further delay these proceedings; is designed for an improper purpose to annoy, embarrass and oppress; is overly broad and unduly burdensome in that it seeks "all" documents. By way of further objection, whether the existence or absence of the requested documents will not support or refute any of their claims or United's affirmative defenses. For these reasons, the Health Care Providers decline to respond to the request.

127. Any and all documents regarding incentive based compensation provided directly or indirectly to physicians or other medical professionals rendering the emergency medical services that form the basis of this litigation.

**RESPONSE:**

Objection. The request is vague and ambiguous as to the terms "incentive based compensation"; seeks information that is not relevant and proportional to the needs of the case as the instance of an such documents, if any, has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; is a request designed to unreasonably further delay these proceedings; is designed for an improper purpose to annoy, embarrass and oppress; is overly broad and unduly burdensome in that it seeks "all" documents. By way of further objection, whether the existence or absence of the requested documents will not support or refute any of their claims or United's affirmative defenses. For these reasons, the Health Care Providers decline to respond to the request.

128. All documents demonstrating whether the physicians or other medical professionals that delivered any of the services at issue in this litigation had input into the amount that was charged or the amount that was collected since July 1, 2017 to the present.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

**RESPONSE:**

Objection. The request is vague and ambiguous as to what amounts charged and/or collected to which it is referring. The request is overly broad and unduly burdensome as the request is not limited to the claims at issue in this case and seeks information that is not relevant and proportional to the needs of the case as the instance of an such documents, if any, has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses. Subject to and without waiving the foregoing objections, the Health Care Providers respond as follows: Non-privileged responsive documents, if any, will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time.

129. All documents reflecting whether TeamHealth had any input into the amount that was charged or the amount that was collected for any of the services at issue in this litigation since July 1, 2017 to the present.

**RESPONSE:**

Objection. The request is not relevant and proportional to the needs of the case as the instance of an such documents, if any, has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses. Subject to and without waiving the foregoing objections, the Health Care Providers respond as follows: Non-privileged responsive documents will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time.

131. All documents reflecting any direct involvement or instruction from Team Health to you regarding the setting of charges, or entering into or negotiating contracts with hospitals or insurers, including rate negotiation.

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McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

**RESPONSE:**

Objection. The request is vague and ambiguous as to the term "direct involvement." The request is overly broad and unduly burdensome as the request is not limited to the claims at issue in this case and seeks documents concerning Team Health's "direct involvement" in entering into or negotiations contracts with hospitals or insurers. The request is not relevant and proportional to the needs of the case as the instance of an such documents, if any, has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses. Further, this request is designed for an improper purpose to annoy, embarrass and oppress. Subject to and without waiving the foregoing objections, the Health Care Providers respond as follows: Non-privileged responsive documents will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time.

132. All documents demonstrating the individuals or entities with ownership, control, or governance of Plaintiffs, including shareholders, owners, officers, board members, etc.

**RESPONSE:**

Objection. This request seeks documents that are confidential; seeks information that is not proportional to the needs of the case as the Health Care Providers' corporate documents has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; is a request designed to unreasonably further delay these proceedings; and is designed for an improper purpose to annoy, embarrass and oppress. For these reasons, the Health Care Providers decline to respond to the request.

133. All documents sufficient to demonstrate whether any individuals at Team Health have acquired the right to own, operate, or manage the Plaintiff entities.

**RESPONSE:**

Objection. This request seeks documents that are confidential; seeks information that is not proportional to the needs of the case as the requested documents have no import as to the

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; is a request designed to unreasonably further delay these proceedings; and is designed for an improper purpose to annoy, embarrass and oppress. For these reasons, the Health Care Providers decline to respond to the request.

134. All documents reflecting the full and complete financial relationship between You and Team Health.

**RESPONSE:**

Objection. This request seeks documents that are confidential; seeks information that is not proportional to the needs of the case as the Health Care Providers' and Team Health's "complete financial relationship" has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; is a request designed to unreasonably further delay these proceedings; and is designed for an improper purpose to annoy, embarrass and oppress. For these reasons, the Health Care Providers decline to respond to the request.

135. All documents sufficient to identify all physicians who, since July 1, 2017 to the present, rendered care relating to the Claims, and whether those physicians are employed—and if so, by whom—or are 1099 independent contractors—and if so, with whom they contract.

**RESPONSE:**

Objection. This request seeks documents that is not proportional to the needs of the case as whether a physician is an employee or independent contractor has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; is a request designed to unreasonably further delay these proceedings; and is designed for an improper purpose to annoy, embarrass and oppress. By way of further objection, Nevada law prohibits United from asking the Health Care Providers to resubmit information already submitted in the claims adjudication process. *See e.g.* NRS

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2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

683A.0879, 689A.410, 689B.255, 689C.485, 695C.185, NAC 686A.675. Subject to and without waiving the foregoing objections, *see* FESM00344.

136. The contracts or employment agreements you have or had with the physicians identified in response to Request 135.

**RESPONSE:**

Objection. This request seeks documents that is not proportional to the needs of the case as whether a physician is an employee or independent contractor has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; and is designed for an improper purpose to annoy, embarrass and oppress. For these reasons, the Health Care Providers decline to respond to the request.

137. All contracts and/or agreements between you and any hospital or facility that were in effect between July 1, 2017 to the present where the emergency medical services relating to the Claims were provided.

**RESPONSE:**

Objection. This request seeks documents that is not proportional to the needs of the case as any contract with a hospital or facility has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; is a request designed to unreasonably further delay these proceedings; and is designed for an improper purpose to annoy, embarrass and oppress. For these reasons, the Health Care Providers decline to respond to the request as currently framed.

138. All documents sufficient to identify any patient financial responsibility forms, including other types of intake documents creating contracts between provider/patient to cover costs/expenses not covered by any health plans insured or administered by Defendants that you provided to patients since July 1, 2017 to the present.

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McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

**RESPONSE:**

Objection. The request is vague and ambiguous as to the terms "patient financial responsibility forms" and "other types of intake documents"; seeks information that is not relevant and proportional to the needs of the case as the instance of an such documents, if any, has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; is a request designed to unreasonably further delay these proceedings; is designed for an improper purpose to annoy, embarrass and oppress; seeks information already in the possession of United; seeks information not in the Health Care Providers' possession because those are generally issued and retained by the hospital; is overly broad and unduly burdensome in that it seeks "all" documents; and violates Nevada law by its request for information that may already be in United's possession. *See e.g.* NRS 683A.0879, 689A.410, 689B.255, 689C.485, 695C.185, NAC 686A.675. By way of further objection, whether the Health Care Providers issued such documents will not support or refute any of their claims or United's affirmative defenses. For these reasons, the Health Care Providers decline to respond to the request as currently framed.

139. All documents demonstrating any instances of Balance Billing by you or suggestions or assertions that you may engage in Balance Billing as it relates to health plans insured or administered by Defendants for the services for which you seek payment in this litigation.

**RESPONSE:**

Objection. The request is vague and ambiguous as to the term "instances of Balance Billing"; seeks information that is not relevant and proportional to the needs of the case as the Health Care Providers' billing practices, if any, identified above have no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; is a request designed to unreasonably further delay these proceedings; is designed for an improper purpose to annoy, embarrass and oppress; is overly broad

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

and unduly burdensome in that it seeks "all" documents." By way of further objection, whether the Health Care Providers bill patients for outstanding amounts due and owing, will not support or refute any of their claims or United's affirmative defenses. Subject to and without waiving the foregoing objections the Health Care Providers respond as follows: Non-privileged responsive documents, if any, will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time.

140. All contracts and other documents relating to your relationship with, and services provided by, any third-party vendor that you used for billing, collection, or revenue-cycle management services from July 1, 2017 to the present.

**RESPONSE:**

Objection. The request seeks information that is not relevant and proportional to the needs of the case as the Health Care Providers' contracts with third-party vendors relating to billing, collection or "revenue-cycle management services", if any, have no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses. The request is also vague and ambiguous with respect to the term "revenue-cycle management services". Subject to and without waiving the foregoing objections, the Health Care Providers respond as follows: Non-privileged responsive documents will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time.

141. All contracts for all leased or rental networks in which you participated from July 1, 2017 to the present.

**RESPONSE:**

Objection. The request seeks information that is not relevant and proportional to the needs of the case as the Health Care Providers' contracts with leased or rental networks, if any, have no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

relationship to any of United's affirmative defenses. Subject to and without waiving the foregoing objections, the Health Care Providers respond as follows: Non-privileged responsive documents will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time.

142. All documents regarding TeamHealth's current employee health plan, including the benefit level, reimbursement methodology, and plan language applicable to claims for reimbursement for out-of-network services received by plan participants.

**RESPONSE:**

Objection. This request seeks documents that are confidential; seeks information that is not proportional to the needs of the case as Team Health's current employee health plan has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; is a request designed to unreasonably further delay these proceedings; and is designed for an improper purpose to annoy, embarrass and oppress. For these reasons, the Health Care Providers decline to respond to the request as currently framed.

143. All data showing the allowed amounts for claims for reimbursement for out-of-network emergency medical services rendered by participants of TeamHealth employee benefit plan at any time since July 1, 2017.

**RESPONSE:**

Objection. This request seeks documents that are confidential; seeks information that is not proportional to the needs of the case as Team Health's current employee health plan has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; and is designed for an improper purpose to annoy, embarrass and oppress. For these reasons, the Health Care Providers decline to respond to the request as currently framed.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

144. All documents regarding TeamHealth's prior, United Healthcare administered plan, including the benefit level, reimbursement methodology, and plan language applicable to claims for reimbursement for out-of-network services received by plan participants.

**RESPONSE:**

Objection. This request seeks documents that are confidential; seeks information that is not proportional to the needs of the case as Team Health's prior United Healthcare administered plan has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; is a request designed to unreasonably further delay these proceedings; and is designed for an improper purpose to annoy, embarrass and oppress. For these reasons, the Health Care Providers decline to respond to the request as currently framed.

145. All data showing the allowed amounts for claims for reimbursement for out-of-network emergency medical services rendered by participants of the plan identified in response to Request 143.

**RESPONSE:**

Objection. This request seeks documents that are confidential; seeks information that is not proportional to the needs of the case as allowed amounts for Team Health's current employee health plan has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; is a request designed to unreasonably further delay these proceedings; and is designed for an improper purpose to annoy, embarrass and oppress. For these reasons, the Health Care Providers decline to respond to the request as currently framed.

146. All documents relating to your entitlement to render services in the facilities at which treatment for the Claims was rendered, including but not limited to licensure, privileges, and credentialing.

...

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

**RESPONSE:**

Objection. This request seeks documents that is not proportional to the needs of the case as the Health Care Provider's licensure, privileges and credentialing has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses; is a request designed to unreasonably further delay these proceedings; and is designed for an improper purpose to annoy, embarrass and oppress. For these reasons, the Health Care Providers decline to respond to the request.

147. All documents you intend to rely upon in this litigation, including documents that you intend to use to support your claimed damages.

**RESPONSE:**

Objection. The Request is overly broad and unduly burdensome in that it seeks "all" documents; is premature as United has refused to produce documents and participate in discovery; and seeks information in United's possession. Subject to and without waiving the foregoing objections, *see* FES_00001; *see also* United's case management information systems that house and retain all of the at-issue claims data that has been submitted by the Health Care Providers, as well as United's electronically stored information yet to be produced.

148. All documents comparing your billed charges to the billed charges of other emergency medical providers in Nevada from July 1, 2017 to present.

**RESPONSE:**

Objection. This request seeks documents not in the Health Care Providers' possession because the particularities of this request would require the Health Care Providers to create a document containing the requested information. Subject to and without waiving the foregoing objections, the Health Care Providers respond as follows: Non-privileged responsive documents, if any, will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

149. All documents referring or relating to the practice of Balance Billing as a tool or source of leverage to pursue higher payments from insurers or third party claims administrators for out-of-network services.

**RESPONSE:**

Objection. The request is duplicative (RFP No. 139); is vague and ambiguous as to the term "practice of Balance Billing" "tool" and "source of leverage"; seeks information that is not relevant and proportional to the needs of the case as the Health Care Providers' billing practices, if any, identified above have no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses because the request seeks information about billing practices related to "any payment received from any Payer"; is designed for an improper purpose to annoy, embarrass and oppress; is not limited to the claims at issue in this case; is a request designed to unreasonably further delay these proceedings; and is overly broad and unduly burdensome in that it seeks "all" documents." By way of further objection, whether the Health Care Providers bill patients for outstanding amounts due and owing, will not support or refute any of their claims or United's affirmative defenses. Subject to and without waiving the foregoing objections, the Health Care Providers respond as follows: Non-privileged responsive documents, if any, will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time

150. All documents demonstrating the extent to which United authorized, pre-authorized and/or approved the services you rendered with respect to the Claims.

**RESPONSE:**

Objection. United already adjudicated the claims submitted by the Health Care Providers; therefore, any request relating to the authorization and/or approval of services rendered with respect to the Claims seeks information that is irrelevant and is not proportional to the needs of the case considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit. By way of further objection, the request is designed for an improper purpose to annoy, embarrass and oppress and is a request designed to unreasonably further delay these proceedings given that pursuant to Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd and NRS 439B.410, the Health Care Providers are obligated to provide emergency medical services to any person presenting to an emergency department it staffs regardless of any prior authorization or approval by an insurer. Subject to and without waiving the foregoing objections, the Health Care Providers respond as follows: Non-privileged responsive documents, if any, will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time.

151. If you contend that any document or agreement entitles you to payment of full billed charges for any of the claims at issue in this litigation, or is otherwise relevant to the amounts paid for any of the claims, please produce each such document and specify the portion(s) thereof that you contend entitle you to a payment of the full billed charges from United.

**RESPONSE:**

Objection. This request is overly broad and unduly burdensome in that it requests all documents relevant to the amounts paid for any of the claims and is not proportional to the needs of the case considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit; and seeks information already in United's possession. In addition, the request is vague and ambiguous with respect to the term "claims". The request also impermissibly requests that the portion of the documents entitling the Health Care Providers to full payment be identified. By way of further objection, United has refused to produce documents and participate in discovery. Subject to and without waiving the foregoing objections, *see* FESM 00344; *see also* United's case management information systems that house and retain all of the at-issue claims data that has been submitted by the Health Care Providers, as

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

well as United's electronically stored information yet to be produced. In addition to the foregoing, the Health Care Providers intend to elicit testimony from their representatives and United's representatives to demonstrate that the Health Care Providers are entitled to full payment of their claims at issue in this litigation.

152. All documents related to any shared savings program or network savings program or agreement (i.e. through Multiplan or similar programs) you participated in or entered into with respect to the Claims.

**RESPONSE:**

Objection. This request is vague and ambiguous with respect to the terms "shared savings program" and "network savings program." In addition, the request is irrelevant and not proportional to the needs of the case considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit. Subject to and without waiving the foregoing objections, the Health Care Providers respond as follows: Non-privileged responsive documents, if any, will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time.

153. All documents demonstrating the direct benefit(s) you allege United received from your provision of services with respect to the Claims at issue.

**RESPONSE:**

Objection. This request seeks a legal conclusion and impermissibly attempts to narrow the type of benefit required for an actionable claim for unjust enrichment under Nevada law. *Topaz Mut. Co. v. Marsh*, 108 Nev. 845, 856, 839 P.2d 606, 613 (1992) (recognizing that benefit in unjust enrichment claim can be indirect). Thus, because the Health Care Providers only allege the existence of an indirect benefit, no evidence of direct benefit will be required at trial. Subject to and without waiving the foregoing objections, the Health Care Providers respond as follows: Non-privileged responsive documents, if any, will be produced by the Health Care Providers following



McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time.

154. All documents reflecting or discussing the methodology you used to calculate or determine rates charged for medical services in Nevada, including, but not limited to, any documents and/or communications you used or created in the process of calculating and/or determining the prevailing charges, the reasonable and customary charges, the usual and customary charges, the average area charges, the reasonable value, and/or the fair market value for medical services in the geographic area, from July 1, 2017 to present.

**RESPONSE:**

Objection. This request is overly broad and unduly burdensome to the extent it requests "all" documents reflecting or discussing the methodology you used to calculate or determine rates charged for medical services in Nevada" and is not proportional to the needs of the case considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit. In addition, the request is not limited to the claims at issue in this litigation which arose out of emergency medicine services. By way of further objection, the request is vague and ambiguous with respect to the phrases "prevailing charges, the reasonable and customary charges, the usual and customary charges, the average area charges, the reasonable value and/or the fair market value." Subject to and without waiving the foregoing objections the Health Care Providers respond as follows: *see* Fairhealth.org. Non-privileged responsive documents will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time.

155. All documents and information needed to understand any data produced in response to this or prior Requests for Production including, but not limited to, data dictionaries and legends for any coded fields and detailed descriptions of parameters and filters used to generate data from July 1, 2017 to the present.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

**RESPONSE:**

Objection. This request is vague and ambiguous as to the terms "date dictionaries," "legends" "detailed descriptions of parameters and filters used to generate data"; seeks information that would require the Health Care Providers to guess as to what United is asking for; seeks confidential and proprietary information. Subject to and without waiving the foregoing objections, the Health Care Providers are unaware of any documents responsive to this request.

DATED this 28th day of September, 2020.

McDONALD CARANO LLP

By: */s/ Kristen T. Gallagher*

Pat Lundvall (NSBN 3761)
Kristen T. Gallagher (NSBN 9561)
Amanda M. Perach (NSBN 12399)
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*

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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**CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 28th day of September, 2020, I caused a true and correct copy of the foregoing **PLAINTIFFS' RESPONSES TO DEFENDANTS' SECOND SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS** to be served via US Mail to the following:

D. Lee Roberts, Jr., Esq.
Colby L. Balkenbush, Esq.
Brittany M. Llewellyn
WEINBERG, WHEELER, HUDGINS,
GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
lroberts@wwhgd.corn
cbalkenbush@wwhgd.corn
bllewellyn@wwhgd.com

*Attorneys for Defendants*

*/s/ Karen Surowiec*
An employee of McDonald Carano LLP

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

# EXHIBIT 7



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EXHIBIT 7

O'Melveny

O'Melveny & Myers LLP
400 South Hope Street
18th Floor
Los Angeles, CA 90071-2899

T: +1 213 430 6000
F: +1 213 430 6407
omm.com

October 23, 2020

**Natasha S. Fedder**
D: +1 213 430 8018
nfedder@omm.com

**VIA E-MAIL**

Kristen Gallagher
Amanda Perach
Pat Lundvall
McDonald Carano
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada, 89102

**Re: *Fremont Emergency Services (Mandavia), Ltd., et. al. v. UnitedHealth Group, Inc. et. al.*, Case No. A-19-792978-B**

Dear Ms. Gallagher, Ms. Perach, and Ms. Lundvall:

003032

We write regarding Plaintiffs' Responses (the "Responses") to Defendants' Second Set of Requests for Production of Documents (the "Requests"). For 89 of the Requests, Plaintiffs have responded with variations of the following: "Non-privileged responsive documents will be produced by the Health Care Providers following the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time."[1] We have reproduced the text of those 89 Requests in Attachment A to this letter for your convenience.

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As you know, the Court adjudicated United's Renewed Motion to Stay during the hearing it held on October 8, 2020, and the Court's order denying the Motion was entered on October 21, 2020. Accordingly, please provide the document productions committed to by Plaintiffs in the Responses by next Friday, October 30, 2020. When Plaintiffs make those productions, we expect that Plaintiffs will also supplement the Responses to indicate whether they are withholding any responsive documents on the basis of any stated objections. *See* Rule 34(b)(2)(C) ("An objection must state whether any responsive materials are being withheld on the basis of that objection.").

Defendants reserve all rights to challenge any objections Plaintiffs interposed to the Requests, and to challenge Plaintiffs' responses and objections to other written discovery Defendants propounded that remains outstanding.

[1] Certain of the responses contain slight modifications to the quoted language, such as "if any." *See, e.g.*, Response to Request No. 45.

O'Melveny

Sincerely,

*/s/ Natasha S. Fedder*

Natasha S. Fedder
*pro hac vice pending*

*Counsel for Defendants*

Enclosure

cc: Lee Roberts (LRoberts@wwhgd.com)
Colby Balkenbush (CBalkenbush@wwhgd.com)
Brittany Llewellyn (BLlewellyn@wwhgd.com)
Dimitri Portnoi (dportnoi@omm.com)
Amanda Genovese (agenovese@omm.com)

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**ATTACHMENT A**

- **Document Production Request No. 23:** Please produce all documents supporting your contention that "[t]he Defendants committed the following crimes of racketeering activity: ... NRS 207.360(36) (involuntary servitude)" as you allege in ¶ 264 of your First Amended Complaint.

- **Document Production Request No. 24:** Please produce all documents supporting your contention that "[t]he Defendants committed the following crimes of racketeering activity: ... NRS 207.360(35) (any violation of NRS 205.377)" as you allege in ¶ 264 of your First Amended Complaint.

- **Document Production Request No. 25:** Please produce all documents supporting your contention that "[t]he Defendants committed the following crimes of racketeering activity: NRS 207.360(28) (obtaining possession of money or property valued at $650 or more)" as you allege in ¶ 264 of your First Amended Complaint.

- **Document Production Request No. 26:** Please produce all documents supporting your contention that "[t]he Defendants, on more than two occasions, have schemed with Data iSight to artificially and, without foundation, substantially decrease non-participating provider reimbursement rates" as you allege in ¶ 269 of your First Amended Complaint.

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- **Document Production Request No. 27:** Please produce all documents supporting your contention that "[a]s a direct and proximate result of Defendants' violations of NRS 207.360(28), (35) and (36), the Health Care Providers have sustained a reasonably foreseeable injury in their business or property by a pattern of racketeering activity" as you allege in ¶ 272 of your First Amended Complaint.

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- **Document Production Request No. 28:** Please produce all documents supporting your contention that "[a]s a direct and proximate result of Defendants' violations of NRS 207.360(28), (35) and (36), the Health Care Providers have ... suffer[ed] substantial financial losses" as you allege in ¶ 272 of your First Amended Complaint.

- **Document Production Request No. 29:** Please produce all documents supporting your contention that "[e]ach Defendant ... knows and willingly participates in the scheme to defraud the Health Care Providers" as you allege in ¶ 271 of your First Amended Complaint.

- **Document Production Request No. 30:** Please produce the "Letter of Concern" referenced in ¶ 108 of your First Amended Complaint.

- **Document Production Request No. 31:** Please produce all documents supporting your contention that Dan Rosenthal and Dan Schumacher made the statements described in ¶¶ 93, 96-98, and 104-105, of your First Amended Complaint.



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- **Document Production Request No. 32:** Please produce the "written proposal" referenced in ¶ 106 of the First Amended Complaint.

- **Document Production Request No. 33:** Please produce all documents demonstrating or confirming that the phone conversations with Data iSight representatives described in ¶¶ 136-140 of your First Amended Complaint occurred.

- **Document Production Request No. 34:** Please produce all documents supporting the "examples" given in ¶¶ 166-172 of your First Amended Complaint.

- **Document Production Request No. 35:** Please produce all documents supporting your contention that the email and phone call by Data iSight described in ¶ 179 of your First Amended Complaint occurred.

- **Document Production Request No. 36:** Please produce all documents supporting your contention that the phone call described in ¶ 180 of your First Amended Complaint occurred.

- **Document Production Request No. 37:** Please produce all documents supporting the "examples" given in ¶ 184 of your First Amended Complaint.

- **Document Production Request No. 45:** Please produce all documents reflecting any of your discussions, deliberations and/or decisions regarding setting, adjusting, and/or maintaining the rates, and each and every component thereof, for each CPT code charged in the Claims. For purposes of this request, the components should include Base Units, Time Units, Modifying Units, and Conversion Factors.

- **Document Production Request No. 46:** Please produce all documents reflecting your decisions to set, adjust (or keep constant) the rates charged, and each and every component thereof, for any of the CPT codes related to the Claims. For purposes of this request, the components should include Base Units, Time Units, Modifying Units, and Conversion Factors.

- **Document Production Request No. 47:** Please produce all documents reflecting any "charge masters" that were used by you that represent your full billed charges for any of the CPT codes related to the Claims from July 1, 2017 to the present.

- **Document Production Request No. 48:** Please produce all documents which you considered from external sources when setting, adjusting (or keeping constant), the rates charged for any of the CPT codes related to the Claims. For purposes of this request, the components should include Base Units, Time Units, Modifying Units, and Conversion Factors from July 1, 2017 to the present.

- **Document Production Request No. 49:** Please produce all documents, including but not limited to reports, analysis, presentations, or studies from any business consulting

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company you retained which addresses the rates which you have charged or should charge for any of the CPT codes related to the Claims from July 1, 2017 to the present.

- **Document Production Request No. 51:** Please produce all reports from any business consulting company, retained by you, which addresses the typical rates at which you received payment, or should have expected as payment, from any Payer for any of the CPT codes reflected in the Claims from July 1, 2017 to the present.

- **Document Production Request No. 53:** Please produce all documents related to any internal "expected payment" amounts or rates you established for any Payer, including the minimum thresholds for automatic appeals and other administrative remedies from July 1, 2017 to the present.

- **Document Production Request No. 54:** Please produce all documents identifying each and every Payer with whom you have or had a contract to provide emergency medical services from July 1, 2017 to present.

- **Document Production Request No. 55:** Please produce all contracts which you have or had with any Payer that reflects any amounts you were willing to accept as payment for any medical-related services that you provided from July 1, 2017 to present.

- **Document Production Request No. 56:** Please produce all documents relating to any complaints by your patients regarding any amounts charged, including but not limited to any patient Balance Billing for services you provided from July 1, 2017 to present, including but not limited to informal and formal complaints and/or challenges.

- **Document Production Request No. 57:** Please produce all documents reflecting complaints by administrators or employees of hospitals or other facilities/organizations providing emergency medical services concerning the amounts charged by you for emergency medical services you provided from July 1, 2017 to present, including but not limited to informal and formal complaints and/or challenges.

- **Document Production Request No. 60:** Please produce all documents which identify the members of any groups, committees, or entities, with responsibility for setting, adjusting or maintaining the rates you charge for emergency medical services, including your billing committee(s), if any, from July 1, 2017 to present.

- **Document Production Request No. 71:** Please produce all copies of the minutes of any meetings of any groups, committees and/or entities, with responsibility for setting, adjusting, or maintain the rates which Plaintiffs charge for emergency medical services from July 1, 2017 to present.

- **Document Production Request No. 77:** Please produce all documents demonstrating that Defendants have paid you at rates less than those you allege you are entitled to receive with respect to the Claims.

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- **Document Production Request No. 78:** Please produce all documents demonstrating that Defendants paid less than what you allege to be the fair value for your services at issue in your First Amended Complaint.

- **Document Production Request No. 79:** Please produce all documents demonstrating that your charges for the Claims are the usual and customary provider charges for similar services in the Nevada market.

- **Document Production Request No. 81:** Please produce all documents that demonstrate the rate of reimbursement that you contend Defendants should have paid with respect to each of the Claims.

- **Document Production Request No. 83:** Please produce all documents and/or data you referred to, reviewed, considered, or relied upon in any way, at any time, to determine the amount to bill on each Claim, or for the types of services at issue in the Claims since July 1, 2017.

- **Document Production Request No. 84:** Please produce all your policies and/or procedures, in effect at any time since July 1, 2017, for writing-off or excusing payments for any emergency medical services rendered.

- **Document Production Request No. 87:** For each Commercial Payer (not including Defendants) with whom you have or had an in-network contractual relationship during the period July 1, 2017 to present, all documents showing, on an annual basis:

    a. The identity of the Payer;

    b. The total number of emergency-related services provided to members of each Payer;

    c. The total charges you billed to each Payer;

    d. The total amount allowed by each Payer;

    e. The total amount paid by each Payer;

    f. The total out-of-pocket patient responsibility related to each Payer's claims;

    g. The total amount you collected from the Payer's members; and

    h. The average percentage of your billed charges that you received from each Payer.

- **Document Production Request No. 88:** For each Commercial Payer (other than Defendants) with whom you do not have or did not have an in-network contractual relationship during the period July 1, 2017 to present, all documents showing, on an annual basis:

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a. The identity of the Payer;

b. The total number of emergency-related services provided to members of each Payer;

c. The total charges you billed to each Payer;

d. The total amount allowed by each Payer;

e. The total amount paid by each Payer;

f. The total out-of-pocket patient responsibility related to each Payer's claims;

g. The total amount you collected from the Payer's members; and

h. The average percentage of your billed charges that you received from each Payer.

- **Document Production Request No. 106:** All documents which reflect any and all internal analysis that you performed, or which were performed on your behalf, regarding payment rates typically exchanged in the Nevada market, from July 1, 2017.

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- **Document Production Request No. 107:** All documents, including but not limited to contracts, showing services which any vendors provided you related to billing or submitting claims, reimbursement, collections, determination of the value of services, the setting of Charge Description Master pricing and/or billed charges from July 1, 2017 to present.

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- **Document Production Request No. 109:** All contracts and/or agreements between you and any reimbursement claims specialists or other business entity that were in force anytime from July 1, 2017 to the present which relate to:

a. Reimbursement for emergency medical claims;

b. Pricing for emergency medical claims;

c. The Claims in dispute in this lawsuit; and

d. Defendants.

- **Document Production Request No. 110:** All documents reflecting communications between you and Team Health regarding reimbursement for emergency medical claims from July 1, 2017 to the present.

- **Document Production Request No. 112:** All documents reflecting communications between you and Team Health regarding pricing for emergency medical claims from July 1, 2017 to the present.



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- **Document Production Request No. 114:** All documents reflecting communications between you and Team Health regarding any of the Claims from July 1, 2017 to the present.

- **Document Production Request No. 116:** All documents reflecting communications between you and Team Health regarding the Claims from July 1, 2017 to the present.

- **Document Production Request No. 118:** All documents, including but not limited to contracts, showing services which Team Health provided to you related to billing or submitting claims, reimbursement, collections, determination of the value of services, the setting of Charge Description Master pricing and/or billed charges from July 1, 2017 to the present.

- **Document Production Request No. 119:** All documents, including but not limited to contracts, showing services which any reimbursement claims specialist or other business entity provided to you related to billing or submitting claims, reimbursement, collections, determination of the value of services, the setting of Charge Description Master pricing and/or bi) led charges from July 1, 2017 to the present.

- **Document Production Request No. 120:** All documents from Team Health, which provide instructions, directives or guidance for maximizing reimbursements for out-of-network claims from July 1, 2017 to the present.

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- **Document Production Request No. 121:** All documents from any business entity which provides instructions, directives, or guidance for maximizing reimbursements for out-of-network claims from July 1, 2017 to the present.

- **Document Production Request No. 122:** All documents reflecting communications between you and Team Health, from July 1, 2017 to the present, regarding instructions, directives or guidance which relate to:

    a. Reimbursement for emergency medical claims;

    b. Pricing for emergency medical claims;

    c. The Claims in dispute in this lawsuit; and

    d. Defendants.

- **Document Production Request No. 123:** All documents reflecting communications between any you and any business entity, from July 1, 2017 to the present, regarding instructions, directives or guidance which relate to:

    a. Reimbursement for emergency medical claims;

    b. Pricing for emergency medical claims;



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c. The Claims in dispute in this lawsuit; and

d. Defendants.

- **Document Production Request No. 128:** All documents demonstrating whether the physicians or other medical professionals that delivered any of the services at issue in this litigation had input into the amount that was charged or the amount that was collected since July 1, 2017 to the present.

- **Document Production Request No. 129:** All documents reflecting whether TeamHealth had any input into the amount that was charged or the amount that was collected for any of the services at issue in this litigation since July 1, 2017 to the present.

- **Document Production Request No. 131:** All documents reflecting any direct involvement or instruction from Team Health to you regarding the setting of charges, or entering into or negotiating contracts with hospitals or insurers, including rate negotiation.

- **Document Production Request No. 139:** All documents demonstrating any instances of Balance Billing by you or suggestions or assertions that you may engage in Balance Billing as it relates to health plans insured or administered by Defendants for the services for which you seek payment in this litigation.

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- **Document Production Request No. 140:** All contracts and other documents relating to your relationship with, and service provided by, any third-party vendor that you used for billing, collection, or revenue-cycle management services from July 1, 2017 to the present.

- **Document Production Request No. 141:** All contracts for all leased or rental networks in which you participated from July1, 2017 to the present.

- **Document Production Request No. 148:** All documents comparing your billed charges to the billed charges of other emergency medical providers in Nevada from July 1, 2017 to present.

- **Document Production Request No. 149:** All documents referring or relating to the practice of Balance Billing as a tool or source of leverage to pursue higher payments from insurers or third patty claims administrators for out-of-network services.

- **Document Production Request No. 150:** All documents demonstrating the extent to which United authorized, preauthorized and/or approved the services you rendered with respect to the Claims.

- **Document Production Request No. 152:** All documents related to any shared savings program or network savings program or agreement (i.e. through Multiplan or similar programs) you participated in or entered into with respect to the Claims.



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- **Document Production Request No. 153:** All documents demonstrating the direct benefit(s) you allege United received from your provision of services with respect to the Claims at issue.

- **Document Production Request No. 154:** All documents reflecting or discussing the methodology you used to calculate or determine rates charged for medical services in Nevada, including, but not limited to, any documents and/or communications you used or created in the process of calculating and/or determining the prevailing charges, the reasonable and customary charges, the usual and customary charges, the average area charges, the reasonable value, and/or the fair market value for medical services in the geographic area, from July 1, 2017 to present.

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# EXHIBIT 8



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EXHIBIT 8

O'Melveny

O'Melveny & Myers LLP
400 South Hope Street
18th Floor
Los Angeles, CA 90071-2899

T: +1 213 430 6000
F: +1 213 430 6407
omm.com

November 17, 2020

**Natasha S. Fedder**
D: +1 213 430 8018
nfedder@omm.com

**VIA E-MAIL**

Kristen Gallagher
Amanda Perach
Pat Lundvall
McDonald Carano
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102

**Re: *Fremont Emergency Services (Mandavia), Ltd., et. al. v. UnitedHealth Group, Inc. et. al.*; Case No. A-19-792978-B; Outstanding Discovery**

Dear Ms. Gallagher, Ms. Perach, and Ms. Lundvall:

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Following up on our October 23, 2020 letter, we again write regarding Plaintiffs' Responses to Defendants' Second Set of Requests (the "Requests") for Production of Documents (the "Responses"). In response to 54 of the Requests—*i.e.*, over one-third of them—you responded in full or in part as follows: "**the Health Care Providers decline to respond to the request**."

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As a threshold matter, the boilerplate objections Plaintiffs interposed in support of their refusal to produce documents are meritless. *See Partner Weekly, LLC v. Viable Mktg. Corp.*, 2014 WL 1577486, at *2 (D. Nev. Apr. 17, 2014) ("Boilerplate and generalized objections are inadequate and tantamount to no objection at all"). What is more, "boilerplate objections are disfavored, especially when a party fails to submit any evidentiary declarations supporting such declarations." *EnvTech, Inc. v. Suchard*, 2013 WL 4899085, at *4 (D. Nev. Sept. 11, 2013) (internal citations omitted). It is undisputed that Plaintiffs have not provided any such declaration here. Further, if Plaintiffs are objecting to part of a request, Plaintiffs "must specify the part and permit inspection of the rest." Nev. R. Civ. P. 34. Finally, Plaintiffs' preference to "decline to respond" does not supply a basis for failure to engage in good faith in discovery in this case.

*A) Improper Boilerplate Objections*

Plaintiffs' boilerplate "vague and ambiguous" objections to Request Nos. 45, 46, 47, 48, 49, 61, 62, 63, 64, 65, 66, 67, 68, 73, 74, 85, 86, 91, 92, 93, 94, 101, 102, 103, 104, 105, 124, 125, 126, 127, and 138 do not explain why the terms are unclear, identify the multiple interpretations, or select a reasonable interpretation of those terms. Furthermore, there can be no serious question as to the meaning of terms like "CPT codes related to Claims" (Request



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Nos. 47, 48, and 49), "reflecting your corporate structure" (Request No. 61), or "internal audit" and "billing practices" (Request No. 73).

Along similar lines, Plaintiffs' boilerplate "overly broad" objections to Request Nos. 62, 80, 85, 100, 101, 102, 103, 104, 105, 108, 124, 125, 126, 127, and 138 largely fail to explain why these requests are overbroad or why Defendants should be satisfied with an incomplete set of the requested documents. A party asserting an "overly broad" objection must state the objection with specificity, explaining how the objection relates to the requested documents. *See Krause v. Nevada Mut. Ins. Co.*, 2014 WL 496936, at *4-6 (D. Nev. Feb. 6, 2014), *aff'd*, 2014 WL 3592655 (D. Nev. July 21, 2014). Plaintiffs fail to do so here. In addition, a subset of the over breadth objections purportedly take issue with variations of requests seeking "all documents." There is no recognized prohibition against the use of the word "all" in a request for production.

Plaintiffs also interpose a number of "improper purpose" objections to Request Nos. 45, 46, 61, 62, 63, 64, 65, 66, 67, 68, 69, 73, 74, 85, 86, 89, 90, 91, 92, 93, 94, 95, 98, 99, 101, 102, 103, 104, 105, 108, 124, 125, 126, 127, 132, 133, 134, 136, 137, 138, 142, 143, 144, 145, and 146. These objections likewise fail to provide Defendants with sufficient information to understand which documents Plaintiffs object to providing and for what specific reason.

*B) Objections Citing Nevada Law*

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Additionally, Plaintiffs assert in their responses to Request Nos. 80, 101, 102, 105, and 138 that "any attempt to object to the coding previously designated by the Health Care Providers violates Nevada law" or that the Request "violates Nevada law by its request for information that may already be in United's possession." In support of these assertions, Plaintiffs cite to a number of statutes pertaining to the approval or denial of health insurance claims. None of these statutes, however, preclude the disclosure of the documents requested or indicate which, if any, would already be in United's possession. *See* Nev. Rev. Stat. Ann. §§ 683A.0879 (establishing requirements such as time limits for the approval and payment of health insurance claims), 689A.410 (restating the requirements outlined in § 683A.0879), 689B.255, 689C.485 (establishing requirements such as time limits for the approval and payment of group health insurance claims), and 695C.185 (establishing requirements such as time limits for the approval and payment of health insurance claims to health maintenance organizations); Nev. Admin. Code § 686A.675 (establishing standards for processing claims applicable to all insurers). Plaintiffs fail to explain how these provisions, which appear utterly inapposite, support their objections.

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*C) Privilege Objections*

Plaintiffs' objections to Request Nos. 61, 67, 68, 73, 74, 86, 92, 93, and 94 rest on the grounds that they "potentially seek[] documents protected by the attorney-client privilege and work product doctrine and/or are otherwise confidential." To the extent that there are any responsive, privileged documents, please provide a privilege log in accordance with NRCP 26(b)(5). As for responsive confidential documents, Plaintiffs can designate them in accordance with the protective order on file in this case, as Plaintiffs themselves have recognized. *See* Oct.

8, 2020 Transcript of Proceedings re: Motions at 59:23-60:3 ("United also objects to . . . some of the issues with respect to trade secrets under the Nevada statute, and it's [sic] proprietary information as well as their customer information. I think . . . we're well established at this point that we have a protective order. United is not shy about identifying things that is attorneys' eyes only. So I think that provides the most protection."). In addition, Defendants are willing to accept data that blinds or redacts identifying information for non-United payers.

*D) Relevancy Objections*

Plaintiffs "declined to respond" to an overwhelming majority of the Requests because they purportedly have "no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor [do they] have any bearing on or relationship to any of United's affirmative defenses." However, Nevada employs a liberal discovery standard that permits discovery into "any nonprivileged matter that is relevant to any party's claims or defenses and proportional to the needs of the case . . . ." Nev. R. Civ. P. 26(b)(1). Any party objecting to production on relevance grounds "has the burden of clarifying, explaining and supporting its objections." *Painters Joint Comm. v. Employee Painters Tr. Health & Welfare Fund*, 2011 WL 4573349, at *5 (D. Nev. Sept. 29, 2011), order corrected on reconsideration sub nom. *Painters Joint Comm. v. J.L. Wallco, Inc.*, 2011 WL 5854714 (D. Nev. Nov. 21, 2011); *Koninklijke Philips Elecs. N.V. v. KXD Tech.*, Inc., 2007 WL 778153, at *4 (D. Nev. Mar. 12, 2007) (To meet the burden of showing that "discovery is overly broad, unduly burdensome or not relevant," "the objecting party must specifically detail the reasons why each request is irrelevant").[1] To meet this burden, the objecting party "must specifically detail the reasons why each request is irrelevant." *Id*. Finally, "[f]or discovery purposes, relevance means only that the materials sought are reasonably calculated to lead to the discovery of admissible evidence." *See F.T.C. v. AMG Servs.*, Inc., 291 F.R.D. 544, 552, 556 (D. Nev. 2013). Despite their burden, Plaintiffs' responses fail to explain why the Requests are of no import to this case. They cannot do so because there can be no serious question that the Requests are of high import, as follows:

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1. Plaintiffs' Corporate Structure

Request Nos. 61, 69, and 132 seek the following categories of documents:

- *All documents reflecting your corporate structure for each year from July 1, 2017 to the present*. (Request No. 61).

- *All any and all articles of incorporation, amendments and governing documents for each of the Plaintiffs in effect at any time from July 1, 2017 to present*. (Request No. 69).

[1] As you know, discovery disputes in the context of Federal Rule of Civil Procedure 26(b) are applicable as the Nevada discovery rules mirror the federal rules. *See Executive Mgmt. v. Ticor Title Ins. Co.*, 118 Nev. 46, 53, 38 P.3d 872, 876 (2002) ("Federal cases interpreting the Federal Rules of Civil Procedure 'are strong persuasive authority, because the Nevada Rules of Civil Procedure are based in large part upon their federal counterparts.'" (quoting *Las Vegas Novelty v. Fernandez*, 106 Nev. 113, 119, 787 P.2d 772, 776 (1990))).

- *All documents demonstrating the individuals or entities with ownership, control, or governance of Plaintiffs, including shareholders, owners, officers, board members, etc*. (Request No. 132).

Documents demonstrating individuals or entities with ownership, control, or governance of Plaintiffs such as TeamHealth, Plaintiffs' respective boards of directors or governing bodies, or any groups or committees charged with the task of reviewing or setting rates inform many issues, including identification of the individuals or entities who have decisional input concerning the setting of Plaintiffs' charges, and the decisions concerning whether to accept an amount below billed charges. Whether any of these individuals or entities has a financial incentive to influence the rates or the amounts of payment that Plaintiffs would accept calls into question the objectivity of the charged amount and whether the charges are set in good faith. This is all the more relevant here as Plaintiffs appear to be contending that up to 90% of their full, unilaterally-set billed charges reflect a reasonable reimbursement rate. *See* First Amended Complaint, Doc. 40 at ¶ 54 (filed January 7, 2020) (alleging that, "a reasonable reimbursement rate for the Health Care Providers' Non-Participating Claims for emergency services is ***75-90% of the Health Care Providers' billed charge***") (emphasis added).

2. Relationship between Plaintiffs and TeamHealth

Request Nos. 95, 108, 133, 134, 142, 143, 144, and 145 seek the following categories of documents:

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- *Documents which show the relationship between Plaintiffs and Team Health from July 1, 2017 to present, including but not limited to documents showing the services provided to you by Team Health, any compensation Team Health received in connection with those services (including remuneration flowing between you and Team Health or collected reimbursement that Team Health keeps), and documents showing any Team Health ownership and/or control over you.* (Request No. 95).

- *All contracts, arrangements and/or agreements between you and Team Health, Inc., that were in force anytime July 1, 2017 to the present which relate to:*

  *(a) Reimbursements for emergency medical claims;*

  *(b) Pricing for emergency medical claims;*

  *(c) The Claims in dispute in this lawsuit;*

  *(d) Defendants.*

  (Request No. 108).

- *All documents sufficient to demonstrate whether any individuals at Team Health have acquired the right to own, operate, or manage the Plaintiff entities*. (Request No. 133).

- *All documents reflecting the full and complete financial relationship between You and Team Health*. (Request No. 134).

- *All documents regarding TeamHealth's current employee health plan, including the benefit level, reimbursement methodology, and plan language applicable to claims for reimbursement for out-of-network services received by plan participants*. (Request No. 142).

- *All data showing the allowed amounts for claims for reimbursement for out-of-network emergency medical services rendered by participants of TeamHealth employee benefit plan at any time since July 1, 2017*. (Request No. 143).

- *All documents regarding TeamHealth's prior, United Healthcare administered plan, including the benefit level, reimbursement methodology, and plan language applicable to claims for reimbursement for out-of-network services received by plan participants*. (Request No. 144).

- *All data showing the allowed amounts for claims for reimbursement for out-of-network emergency medical services rendered by participants of the plan identified in response to Request 143*. (Request No. 145).

Plaintiffs responded that that these requests were of "no import," noting in Plaintiffs' response to Request No. 108 that "TeamHealth is not a party to this lawsuit and documents regarding any relationship between the Health Care Providers and TeamHealth do not have any bearing on the dispute at issue in this action." Contrary to these assertions, the relationship between Plaintiffs and TeamHealth informs many issues, including identification of the entities who have decisional input concerning the setting of Defendants' charges and concerning whether to accept an amount below billed charges.

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Whether TeamHealth has a financial incentive to influence the rates or the amounts of payments Plaintiffs would accept calls into question the objectivity of the charged amount and whether the charges are set in good faith, or instead calculated to generate the most money possible for a private equity firm. TeamHealth's strategy of increasing out-of-network rates as a negotiation tactic is well documented, as is Blackstone's need to increase profitability. *See Surprise! Out-of-Network Billing for Emergency Care in the United States*, Cooper, et al., December 2018; *Ill-Timed Health-Care Buyouts Bruise KKR and Blackstone*, Gottfried, Wall Street Journal, May 28, 2020, attached hereto. Also documented are the high dollar figures associated with the administrative services TeamHealth purportedly provides and the management fee it charges. *See How Rich Investors, Not Doctors, Profit From Making Up ER Bills*, Armsdorf, ProPublica, June 12, 2020, attached hereto. Whether the fees for these services inflated Plaintiffs' billed charges for the at-issue claims is relevant to the reasonable value of the underlying medical services. Moreover, ***all*** of the party witnesses Plaintiffs have disclosed appear to be current or former TeamHealth employees. And, discovery to date suggests that most or all of the contractual negotiations that appear to be at issue in this case involved TeamHealth. Accordingly, Plaintiffs' contention that documents regarding TeamHealth are not relevant simply is not credible.

3. Plaintiffs' Billing Practices

Request Nos. 45, 46, 47, 48, 49, 62, 63, 64, 65, 66, 67, and 80 seek the following categories of documents:

- *Please produce all documents reflecting any of your discussions, deliberations and/or decisions regarding setting, adjusting, and/or maintaining the rates, and each and every component thereof, for each CPT code charged in the Claims. For purposes of this request, the components should include Base Units, Time Units, Modifying Units, and Conversion Factors.* (Request No. 45).

- *Please produce all documents reflecting your decisions to set, adjust (or keep constant) the rates charged, and each and every component thereof, for any of the CPT codes related to the Claims. For purposes of this request, the components should include Base Units, Time Units, Modifying Units, and Conversion Factors*. (Request No. 46).

- *Please produce all documents reflecting any "charge masters" that were used by you that represent your full billed charges for any of the CPT codes related to the Claims from July 1, 2017 to the present*. (Request No. 47).

- *Please produce all documents which you considered from external sources when setting, adjusting (or keeping constant), the rates charged for any of the CPT codes related to the Claims. For purposes of this request, the components should include Base Units, Time Units, Modifying Units, and Conversion Factors from July 1, 2017 to the present*. (Request No. 48).

- *Please produce all documents, including but not limited to reports, analysis, presentations, or studies from any business consulting company you retained which addresses the rates which you have charged or should charge for any of the CPT codes related to the Claims from July 1, 2017 to the present*. (Request No. 49).

- *Please produce all documents reflecting your billing practices and procedures from July 1, 2017 to present including, but not limited to:*

  *a) Your decision to appeal (or to not appeal) any payment received from any Payer;*

  *b) The calculation of any amounts you may hold as an uncollected balance on any payment received;*

  *c) Your decision to pursue (or not to pursue) out-of-pocket payment collections from patients.*

  (Request No. 62).

- *Please produce all documents reflecting your practices and procedures regarding the use of Base Units when billing from July 1, 2017 to present*. (Request No. 63).



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- *Please produce all documents reflecting your practices and procedures regarding the use of Time Units when billing from July 1, 2017 to present*. (Request No. 64).

- *Please produce all documents reflecting your practices and procedures regarding the use of Modifying Units when billing from July 1, 2017 to present*. (Request No. 65).

- *Please produce all documents reflecting your practices and procedures regarding the use of Conversion Factors from July 1, 2017 to present*. (Request No. 66).

- *Please produce all documents which reflect your cost to perform each service as represented by the CPT codes charged in the Claims, including but not limited to:*

  *a) Any filed cost report documentation or supporting analyses;*

  *b) Any internal or external cost-to-charge calculations performed by you; and*

  *c) Any external cost-to-charge calculations performed as to Plaintiffs.*

  (Request No. 67).

- *Please produce all documents supporting the medical necessity of the services at issue with respect to the Claims that you contend were performed on an emergency basis in the First Amended Complaint*. (Request No. 80).

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Plaintiffs dubbed these Requests of "no import." Plaintiffs' position cannot be taken seriously here, where the central issue is whether the amounts Defendants allowed as reimbursement for the at-issue claims are reasonable. The services Plaintiffs allegedly rendered and the way they billed for those services is unquestionably relevant to Plaintiffs' ability to prove their claims, and to Defendants' affirmative defenses. *See, e.g.*, Answer at 44 ("Some or all of Plaintiffs' billed charges are excessive under the applicable standards"), 45 ("To the extent that Plaintiffs have any right to receive plan benefits, that right is subject to basic preconditions and prerequisites that have not been established, such as . . . that the services were medically necessary, that an emergency medical condition was present, that Plaintiffs timely submitted correctly coded claims . . . .").

4. Plaintiffs' Actual Cost of Doing Business

Request Nos. 68, 86, 92, 93, and 94 seek the following categories of documents:

- *Please produce all documents which reflect or discuss the extent to which the rates you charge for emergency medical services, from July 1, 2017 to present, capture or reflect your actual cost of doing business*. (Request No. 68).

- *Please produce all documents and communications of any type related to any cost to charge analysis performed on any emergency medical service you offer patients from July 1, 2017 to present*. (Request No. 86).

- *Documents showing each and every cost incurred by you in offering emergency services to patients from July 1, 2017 to present*. (Request No. 92).

- *Documents showing each and every cost incurred by you in offering the types of services reflected in the Claims from July 1, 2017 to present*. (Request No. 93).

- *A copy of any cost report(s) presented by you to any federal or state agency since July 1, 2017 to present*. (Request No. 94).

Plaintiffs respond, among other things, that these Requests have "no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor [do they] have any bearing on or relationship to any of United's affirmative defenses." Contrary to these unsupported assertions, the costs incurred by Plaintiffs in performing emergency medical services is directly relevant to the issue of whether any payment by United was "reasonable" vis-à-vis the value of any services rendered, which Plaintiffs have placed squarely at issue in this case. *See* Am. Compl. ¶ 40 ("Specifically, the reimbursement claims within the scope of this action are (a) nonparticipating commercial claims (including for patients covered by Affordable Care Act Exchange products), (b) that were adjudicated as covered, and allowed as payable by Defendants, (c) *at rates below* the billed charges and *a reasonable payment for the services rendered*, (d) as measured by the community where they were performed and by the person who provided them.") (emphasis added); *see, e.g.*, Answer at 44 ("Some or all of Plaintiffs' billed charges are excessive under the applicable standards").

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5. Audits of Plaintiffs' Billing Practices

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Request Nos. 73, 74, 75, and 76 seek the following categories of documents:

- *Please produce all copies of any internal audits of your billing practices from July 1, 2017 to present*. (Request No. 73).

- *Please produce all copies of any external audits of your billing practices from July 1, 2017 to present*. (Request No. 74).

- *Please produce all documents relating to internal or external audits of your billing practices from July 1, 2017 to present*. (Request No. 75).

- *Please produce copies of any contracts that you entered into with a third party to conduct external audits of your billing practices from July 1, 2017 to present*. (Request No. 76).

Plaintiffs respond, among other things, that these Requests have "no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor [do they] have any bearing on or relationship to any of United's affirmative defenses." Despite this assertion, any audits assessing Plaintiffs' billing practices—and any subsequent changes to Plaintiffs' billing practices—are directly probative of Plaintiffs' allegations that they were reimbursed less than reasonable rates. *See, e.g.*, Am. Compl. ¶ 40; Answer at 44.

6. Plaintiffs' Relationships with Facilities

Request Nos. 126 and 137 seek the following categories of documents:

- *All documents relating to presentations and/or proposals you have made to the facilities where services in question were rendered regarding your emergency medical services.* (Request No. 126).

- *All contracts and/or agreements between you and any hospital or facility that were in effect between July 1, 2017 to the present where the emergency medical services relating to the Claims were provided.* (Request No. 137).

Plaintiffs respond, among other things, that these Requests have "no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor [do they] have any bearing on or relationship to any of United's affirmative defenses." Quite the contrary: What Plaintiffs offer, charge or accept from hospitals/facilities is relevant to the reasonable value of the services. Furthermore, if Plaintiffs offer, charge, or accept different amounts depending on the hospital/facility, then that is probative of the issue of what a reasonable payment looks like.

Request No. 146 seeks the following category of documents:

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- *All documents relating to your entitlement to render services in the facilities at which treatment for the Claims was rendered, including but not limited to licensure, privileges, and credentialing.* (Request No. 146).

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Plaintiffs respond, among other things, that this Request, "has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses." Request No. 146 seeks documents concerning Plaintiffs' relationship with the facilities where they rendered services. For example, it is relevant whether Plaintiffs were the exclusive providers, or among several providers at the facility, and what professional licensure and credentialing requirements Plaintiffs' providers needed to satisfy to render services at the facility. Whether Plaintiffs are subject to competition that could potentially drive down their rates is relevant to whether their charges are reasonable. If, for example, they maintain a monopoly on a facility and can set rates at their discretion without regard to any competitive factors, then the rates they charge may not be reasonable. The professional licensure and credentialing of their providers is likewise informative of whether Plaintiffs' billed charges are reasonable. *Cf. United States v. TeamHealth Holdings*, Civil Action No. 2:16-cv-00432-JRG, Doc. 33 at ¶¶ 2–6 (E.D. Tex. Filed Nov. 12, 2018) (alleging that TeamHealth improperly billed for emergency room physician services when in fact the services were performed by physician assistants whose services are billed at only 85% of the standard physician rate), attached hereto.

7. Financial Incentives

Request Nos. 124, 125, 127, and 136 seek the following categories of documents:

- *All documents concerning compensation, incentives, or renumeration of any sort paid to/credited to you—or anyone with a direct or indirect ownership or control of you, including joint ventures—by hospitals/facilities or their affiliated entities, including joint ventures, where the emergency medical services in question were rendered, whether on a per claim basis, in the aggregate, or by any other means.* (Request No. 124).

- *All documents concerning compensation, incentives, or renumeration of any sort paid by/credited by you—or on your behalf by anyone—to hospitals/facilities or their affiliated entities, including joint ventures, where the emergency medical services in question were rendered, whether on a per claim basis, in the aggregate, or by any other means.* (Request No. 125).

- *Any and all documents regarding incentive based compensation provided directly or indirectly to physicians or other medical professionals rendering the emergency medical services that form the basis of this litigation*. (Request No. 127).

- *The contracts or employment agreements you have or had with the physicians identified in response to Request 135*. (Request No. 136).

Plaintiffs respond, among other things, that these Requests have "no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses." The requested information is unquestionably "of import" because, among other reasons, financial incentives that may have influenced the rates or the amounts of payment Plaintiffs would accept or that Plaintiffs have to pay call into question the objectivity of the charged amount and whether the charges are reasonable. In addition, these Requests seek documents that are informative of whether Plaintiffs (or other entities with an ownership interest in Plaintiffs) received compensation such that Plaintiffs should not receive double recovery. *See* Answer at 48 ("Plaintiffs are not entitled to relief because they have received all payments due, if any, for the covered services they provided in accordance with the terms of their patients' health plans.").

8. Payments from Other Sources

Request Nos. 85, 99, 100, 101, 102, 103, 104, and 138 seek the following categories of documents:

- *Please produce all your policies and/or procedures, in effect at any time since July 1, 2017, relative to the billing of self-pay and/or uninsured patients including but not limiting to any policies for offering and/or accepting less than full billed charges.* (Request No. 85).

- *All documents relating to the comparison of your billed charges for emergency medical services to the reimbursement rates you have agreed to accept by contract from Payers other than Defendants from July 1, 2017 to present.* (Request No. 99).

- *All documents relating to payments that you have received from any source with respect to the Claims asserted in the First Amended Complaint, including, but not limited to, payments received from patients, Defendants and/or other Payers (such as government payers, commercial payers, managed care organizations, and Medicare Advantage plans).* (Request No. 100).

- *All documents that you provided to your patients relating to patient financial responsibility for out-of-network emergency medical services for all of the Claims.* (Request No. 101).

- *All documents that you provided to any of your patients from July 1, 2017 to present related to patient financial responsibility for out-of-network emergency medical services.* (Request No. 102).

- *All documents that you provided to your patients related to actual or potential responsibility to pay you the difference between your billed charges for emergency medical services and the amounts reimbursed by Defendants related to the Claims.* (Request No. 103).

- *All documents that you provided to your patients related to actual or potential responsibility to pay you the difference between your billed charges for emergency medical services and the amounts reimbursed by Commercial Payers from July 1, 2017 to present.* (Request No. 104).

- *All documents sufficient to identify any patient financial responsibility forms, including other types of intake documents creating contracts between provider/patient to cover costs/expenses not covered by any health plans insured or administered by Defendants that you provided to patients since July 1, 2017 to the present.* (Request No. 138).

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Plaintiffs respond, among other things, that these Requests have "no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses." Contrary to these assertions, these Requests are relevant to the central issue in dispute: whether the amounts Defendants allowed as reimbursement for the at-issue claims are reasonable. These requests seek documents detailing the various sources of payments Plaintiffs receive for their claims, which are necessary to assessing whether the payments they receive for their services are "reasonable." In addition, these Requests seek documents that are informative of whether Plaintiffs received compensation such that Plaintiffs should not receive double recovery.

* * * *

We look forward to hearing from you and to receiving documents in response to the Requests.

O'Melveny

Sincerely,

*/s/ Natasha S. Fedder*

Natasha S. Fedder

*Counsel for Defendants*

cc: Lee Roberts (LRoberts@wwhgd.com)
Colby Balkenbush (CBalkenbush@wwhgd.com)
Brittany Llewellyn (BLlewellyn@wwhgd.com)
Lee Blalack (lblalack@omm.com)
Dimitri Portnoi (dportnoi@omm.com)
Amanda Genovese (agenovese@omm.com)

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# EXHIBIT 9

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EXHIBIT 9

O'Melveny

O'Melveny & Myers LLP
400 South Hope Street
18th Floor
Los Angeles, CA 90071-2899

T: +1 213 430 6000
F: +1 213 430 6407
omm.com

December 4, 2020

**Natasha S. Fedder**
D: +1 213 430 8018
nfedder@omm.com

**VIA E-MAIL**

Kristen Gallagher
Amanda Perach
Pat Lundvall
McDonald Carano
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102

**Re: *Fremont Emergency Services (Mandavia), Ltd., et. al. v. UnitedHealth Group, Inc. et. al.*; Case No. A-19-792978-B; Outstanding Discovery**

Dear Ms. Gallagher, Ms. Perach, and Ms. Lundvall:

We write regarding Plaintiffs' deficient responses and objections to several of Defendants' discovery requests.[1] As before, we do so with the hope that the items identified in this letter can be rectified without judicial intervention. Also as before, we find little merit in Plaintiffs' objections. Specifically, we write to draw your attention to the following deficiencies:

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**Defendants' First Set of Requests for Production - July 29, 2019 Responses & June 1, 2020 Supplemental Responses**

**Request No. 2:**

This request seeks "all requests for payment sent by Fremont to any of the Defendants during the time period of July 1, 2017 to present."

Plaintiffs' response to this request is incomplete and unclear. The response provides that "certain portions" of the documents produced "have been withheld pending entry of a protective order." However, no redactions are apparent on the face of the documents that Fremont[2] purports to produce in response to this request, making it impossible for Defendants to identify what, if any, information has been withheld. Defendants therefore request that Plaintiffs

[1] This letter concerns the following responses to Defendants' discovery requests: (1) Plaintiffs' July 29, 2019 and June 1, 2020 responses to Defendants' First Set of Requests for Production; (2) Ruby Crest's September 28, 2020 response to Defendants' First Set of Interrogatories; (3) TeamHealth's September 28, 2020 response to Defendants' First Set of Interrogatories; and (4) Plaintiffs' September 28, 2020 and November 21, 2020 responses to Defendants' Second Set of Requests for Production.

[2] All defined terms herein shall be ascribed the same meaning as in the discovery requests.



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supplement their response to this request clarifying what portions of these documents, if any, have been withheld.

**Request No. 3:**

This request seeks "all Health Insurance Claim Forms sent by Fremont to any of the Defendants during the time period of July 1, 2017 to present."

Plaintiffs responded that this request is overly broad because it seeks "all" Health Insurance Claim Forms and is not properly limited to the claims at issue in this Action. In an effort to compromise, Defendants will limit this request to *all claims Plaintiffs specifically placed at issue in this Action*, as reflected in FESM00344. Defendants request that Plaintiffs supplement their response and produce documents responsive to this request.

**Request No. 13:**

This request seeks "all documents supporting the allegations in paragraph 55 of the Complaint that the UHC Parties acted with 'malice, oppression and/or fraud.'"

Plaintiffs' response to this request is incomplete.

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First, Plaintiffs contend that evidence supporting this allegation is derived from "oral statements made by Defendants' representatives in communications with Fremont representatives and Fremont's affiliates' representatives." Plaintiffs, however, fail to produce proof concerning these oral statements, such as contemporaneous notes/emails memorializing these statements in writing.

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Second, Plaintiffs reference, "[b]y way of example," certain statements in an *unverified* complaint filed by Fremont's affiliates *in a dismissed case* in United States District Court, Middle District of Pennsylvania. It is unclear what relevance an unverified complaint from a dismissed action has here.

Defendants request that Plaintiffs supplement their response to this request and produce all documents supporting their allegations in paragraph 55 of the Complaint. If Plaintiffs contend that they possess no documents responsive to this request to support their allegations, then Plaintiffs' supplemental response should clearly state so.

**Request No. 14:**

This request seeks "all documents showing that Fremont notified any of the Defendants prior to providing medical services to the Defendants' plan members that Fremont expected to be paid by Defendants for the medical services provided to the plan members."

As previously noted in Defendants' January 23, 2020 letter, Plaintiffs' response to this request includes improper boilerplate objections. For example, Plaintiffs do not explain why

they deemed the self-explanatory phrase "notified any of the Defendants prior to providing medical services" vague and ambiguous. Defendants previously requested that Plaintiffs supplement their response to this request by removing all boilerplate objections and specifically stating whether they possess responsive documents. As of this date, they have not done so.

While Plaintiffs have cited documents as purporting to be responsive to this request, when reviewed, the documents are neither communications nor notices provided *by Fremont*—instead, they contain general information from the Defendants' website or information regarding individual claims. Defendants therefore request, once more, that Plaintiffs supplement their response and produce documents responsive to this request.

**Request No. 17:**

This request seeks "all communication between Fremont and Defendants concerning the Healthcare Claims that Fremont is asserting in this Action."

Plaintiffs' response to this request is incomplete. To start, Plaintiffs note that Fremont "has discussed the unsatisfactory rate of payment received from the Defendants through numerous oral communications between Fremont's representatives and Defendants' representatives which will be elicited at trial." However, much like their deficient response to Request No. 13, *supra*, Plaintiffs fail to produce proof concerning these oral statements, such as contemporaneous notes/emails memorializing these statements in writing. The documents Plaintiffs purport to have produced in response to this request, *see* FESM000001-8, contain no such communications.

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Defendants request that Plaintiffs supplement their response to this request and produce the requested communications. If Plaintiffs contend that they possess no documents responsive to this request, then Plaintiffs' supplemental response should clearly state so.

**Request No. 22:**

This request seeks "all written agreements with any third parties concerning the Healthcare Claims that Fremont is asserting in this Action."

Plaintiffs failed to respond to this request entirely, instead objecting as to over breadth, relevance, and proportionality. To start, the boilerplate "overly broad" objection impermissibly fails to explain why this request is overbroad. As Defendants have explained in prior correspondence, a party asserting an "overly broad" objection must state the objection with specificity, explaining how the objection relates to the requested documents. *See Krause v. Nevada Mut. Ins. Co.*, 2014 WL 496936, at *4-6 (D. Nev. Feb. 6, 2014), *aff'd*, 2014 WL 3592655 (D. Nev. July 21, 2014). Plaintiffs fail to do so here, perhaps because there is no reasonable argument that the request is overbroad—indeed, this request seeks written agreements with third parties concerning the claims Fremont is specifically placing at issue in this Action.

Nor is Plaintiffs' relevance objection meritorious. Plaintiffs claim that "the existence of any prior written agreement entered into with third parties … has no impact on Defendants' obligation to pay the appropriate rate for the Healthcare Claims." This is patently incorrect. Requests related to agreements with third parties are directly relevant to this case *and* the Healthcare Claims, as the central dispute is whether the benefit amounts reimbursed for the at-issue claims are reasonable. Plaintiffs should also be aware, if diligence was conducted, that they *specifically placed at issue* claims that were adjudicated and paid at par rates based on contracts with third parties. These types of contracts are therefore relevant and discoverable.[3]

Defendants request that Plaintiffs supplement their response to this request and produce the requested agreements, including any agreements with third party preferred provider organizations ("PPO"), wrap/rental network agreements, direct agreements with any self-funded employee plan or self-funded customer administered by Defendants, or other rate agreements negotiated with third parties, including any amendments and rate/reimbursement schedules thereto.

**Defendants' First Set of Interrogatories to Ruby Crest - September 28, 2020 Responses**

**Interrogatory No. 4:**

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This interrogatory asks that "[t]o the extent Ruby Crest contends that any of the Defendants orally promised/committed to reimburse Ruby Crest at a particular rate for the Non-Participating Claims that Ruby Crest contends it is asserting in this Action," Ruby Crest "identify the individual who made the oral promise/commitment, the approximate date the oral promise/commitment occurred, which Ruby Crest employee the oral promise/commitment was made to, and describe in detail the nature of the oral promise/commitment."

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Ruby Crest's objections to this interrogatory are boilerplate, moot, or otherwise improper.

First, Ruby Crest's objection on the basis that this request is vague and ambiguous as to the term "oral promise/commitment" amounts to an improper boilerplate objection, because they do not explain why the terms are unclear, identify the multiple interpretations, or select a reasonable interpretation of those terms. *See Partner Weekly, LLC v. Viable Mktg. Corp.*, 2014 WL 1577486, at *2 (D. Nev. Apr. 17, 2014) ("Boilerplate and generalized objections are inadequate and tantamount to no objection at all"). This objection is particularly confounding for the straightforward phrase "oral promise/commitment."

Second, although Ruby Crest committed to producing non-privileged responsive documents to this interrogatory after the Court ruled on Defendants' Renewed Motion to Stay well over a month ago, Ruby Crest has not yet supplemented its response to this interrogatory or produced responsive documents. Ruby Crest has also failed to provide an explanation for

[3] Defendants produced certain contracts with third parties—that were in their possession—in response to Plaintiffs' Interrogatory No. 7. *See* Defendants' Second Supplemental Responses to Fremont's First Set of Interrogatories.

this delay. Defendants request that Ruby Crest supplement its response to this interrogatory and produce the responsive documents, if any.

**Interrogatory No. 5:**

This interrogatory requests that Ruby Crest "[i]dentify and describe the actions taken by Defendants that led to the creation of the implied contract alleged by Ruby Crest in paragraph 200 in the First Amended Complaint."

Ruby Crest's response to this interrogatory is unclear, as it begins by stating that "Team Physicians responds . . ." Defendants request that Ruby Crest please clarify whether this reference to "Team Physicians" was simply a scrivener's error or if, instead, Ruby Crest is responding on behalf of TeamHealth as a whole, as an affiliated entity of TeamHealth.

**Defendants' First Set of Interrogatories to TeamHealth Physicians - September 28, 2020 Responses**

**Interrogatory No. 4:**

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This interrogatory asks that "[t]o the extent [TeamHealth] contends that any of the Defendants orally promised/committed to reimburse [TeamHealth] at a particular rate for the Non-Participating Claims that [TeamHealth] contends it is asserting in this Action," TeamHealth "identify the individual who made the oral promise/commitment, the approximate date the oral promise/commitment occurred, which TeamHealth employee the oral promise/commitment was made to, and describe in detail the nature of the oral promise/commitment."

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TeamHealth's response to this interrogatory contains many of the same deficiencies as Ruby Crest's response to Interrogatory 4, *supra*. Specifically, the objection on the basis that this interrogatory is vague and ambiguous as to the term "oral promise/commitment" amounts, again, to an improper boilerplate objection.

In addition, TeamHealth's September 28, 2020 response to this interrogatory contains a reference to an incomplete citation: "See FESM_ (Explanation of Benefits consistent with the foregoing)." Defendants request, as part of Plaintiffs' supplemental response to this interrogatory, that Plaintiffs also provide the complete citation.

**Defendants' Second Set of Requests for Production - September 28, 2020 Responses and November 21, 2020 Supplemental Responses**

**Request No. 44:**

This request seeks "all documents identified in [Plaintiffs'] responses to Defendants' Second Set of Interrogatories."

Plaintiffs initially responded that non-privileged documents would be produced following the Court's adjudication of Defendants' Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time. Again, the Court entered an order on that motion over a month ago, and Plaintiffs' November 21, 2020 supplemental responses failed to include any documents responsive to this request.

Defendants request that Plaintiffs supplement their response to this request and produce the requested documents.

**Request No. 97:**

This request seeks the "Provider Tax ID number for all documents related to [Plaintiffs'] determination and/or calculation of the billed charges for the Claims asserted in the First Amended Complaint."

Plaintiffs have failed to respond to this request; instead, they have asserted boilerplate objections that this request is "vague, ambiguous and unintelligible," and that they will reconsider responding to this request upon further clarification. Despite Plaintiffs' failure to explain what is vague, ambiguous, or unintelligible about this request, and their failure to reframe and respond to the request,[4] Defendants state that they are seeking the Provider Tax ID number used to submit claims documentation to Defendants for adjudications and reimbursement for each of the claims Plaintiffs' specifically placed at issue.

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Defendants request that Plaintiffs supplement their response to this request and produce the requested documents.

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* * * *

We look forward to hearing from you and to receiving supplemental responses and document productions by December 11, 2020. If you believe the parties need to confer regarding any of the foregoing, please let us know immediately.

All of Defendants' rights are reserved.

[4] *See Oliva v. Cox Commc'ns Las Vegas, Inc.*, 2018 WL 6171780, at *1 (D. Nev. Nov. 26, 2018) (burden is on the party resisting discovery to "specifically detail" the reasons why each request is objectionable, and "[a]rguments against discovery must be supported by specific examples and articulated reasoning").

O'Melveny

Sincerely,

*/s/ Natasha S. Fedder*

Natasha S. Fedder

*Counsel for Defendants*

cc: Lee Roberts (LRoberts@wwhgd.com)
Colby Balkenbush (CBalkenbush@wwhgd.com)
Brittany Llewellyn (BLlewellyn@wwhgd.com)
Lee Blalack (lblalack@omm.com)
Dimitri Portnoi (dportnoi@omm.com)
Amanda Genovese (agenovese@omm.com)

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# EXHIBIT 10



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EXHIBIT 10

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Steven D. Grierson
CLERK OF THE COURT

**OPPM**
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*

**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,

vs.

UNITEDHEALTH GROUP, INC., a Delaware corporation; 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; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20,

Defendants.

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

**PLAINTIFFS' OPPOSITION TO MOTION TO EXTEND DISCOVERY DEADLINES AND CONTINUE TRIAL SETTING ON ORDER SHORTENING TIME**

Hearing Date: December 23, 2020
Hearing Time: 9:30 a.m.

Plaintiffs Fremont Emergency Services (Mandavia), Ltd. ("Fremont"); Team Physicians of Nevada-Mandavia, P.C. ("Team Physicians"); Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine ("Ruby Crest" and collectively the "Health Care Providers") oppose the



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motion to extend discovery deadlines and continue the August 2, 2021 jury trial filed by defendants UnitedHealth Group, Inc.; UnitedHealthcare Insurance Company; United HealthCare Services, Inc.; UMR, Inc.; Oxford Health Plans, Inc.; Sierra Health and Life Insurance Co., Inc.; Sierra Health-Care Options, Inc.; and Health Plan of Nevada, Inc. (collectively, "United") because good cause does not exist.

This opposition is based upon the record in this matter, the points and authorities that follow, the pleadings and papers on file in this action, and any argument of counsel entertained by the Court.

## POINTS AND AUTHORITIES

### I. INTRODUCTION AND RELEVANT BACKGROUND

United's motion to extend all non-fact discovery deadlines and continue a trial not even set to begin until August 2, 2021 (on a five-week stack) is, unfortunately, not surprising. United has forecasted its intent to delay from the very outset (and even before) the Health Care Providers commenced this action. The Court is familiar with United's methods – having occasion to inform United that its discovery conduct is not acceptable (October 27, 2020 Order at ¶¶ 9-10; November 9, 2020 Order at ¶ 1) – the outcome of which has resulted in the Health Care Providers needing additional time to complete fact discovery.[1] There is no mistake that United's conduct is directly aimed at trying to delay resolution of this case, an objective also embodied in United's simultaneous prosecution of a motion to stay these proceedings before the Nevada Supreme Court pending resolution of a writ petition challenging the Court's order denying United's motion to dismiss. While the Health Care Providers can no longer protect the December 30, 2020 fact discovery deadline because to do so would prejudice their ability to prosecute their claims given United's discovery failures, there is no separate reason to extend

[1] United's lack of diligence and participation resulted in the Health Care Providers proposing a 60-day extension of the fact discovery deadline only. United responded with a 90-day proposal of all discovery deadlines, but did not make any reference to the trial date, stating: "Please let us know if you are agreeable to a 90-day extension of all discovery deadlines." Exhibit 1, Gallagher Decl. ¶ 3. In an effort to compromise, the Health Care Providers offered to split the difference and proposed a 75-day fact discovery extension, but communicated that they are not amenable to extension of any other discovery deadline. *Id.* ¶ 4.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966



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any other discovery deadline or the August 2, 2021 jury trial setting. The Health Care Providers respectfully request the Court deny United's motion.

## II. LEGAL ARGUMENT

### A. United Has Not Articulated Any Basis to Extend Non-Fact Discovery Deadlines

In an effort to justify its request to extend all other discovery deadlines, United claims that this case is still in its infancy. This case commenced in April 2019 and the Health Care Providers have conducted significant discovery to date. It is hard to fathom that a case pending for 20 months could be described as being in its "infancy."

United points to unilaterally contrived scenarios in an effort to justify extending all non-fact discovery deadlines. United first refers to discovery issued long ago (dating back to January 2020) and to which it has only recently initiated meetings to discuss the Health Care Providers' responses. Motion at 11:3-9. With respect to more recently issued written discovery, United did not ask the Health Care Providers to meet and confer in a way that would be compliant with EDCR 2.34(b), instead choosing to write letters (albeit by an out-of-state attorney not then-admitted to practice in this case). *See* Motion, Exs. B and C, October 23, and November 17, 2020 letters from Natasha Fedder, respectively. It was the Health Care Providers' counsel that responded with a request to discuss telephonically. Ex. 1 at ¶ 5. Otherwise, it seems United intended to drag out the required process even longer – likely slow-playing so that it could manufacture discovery disputes abutting the December 30 fact deadline. Such gamesmanship should not be rewarded.

United also tries to paint the Health Care Providers as less than diligent in their responses to United's written discovery requests; however, many of United's discovery requests are focused on matters that do not inform this rate-of-payment case. For example, United asked the Health Care Providers to produce documents relating to the corporate structure of TeamHealth Holdings, produce documents related to the Health Care Providers' costs of doing business and contracts between the Health Care Providers and the hospitals where they provide emergency services. Motion, Ex. C at p.3-4, 7, 9. United has already tried this distraction with non-relevant

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966



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requests in another case pending in Florida. There, the state court sustained the provider's objections to United's requests for corporate structure documents, stating:

> The Objections to Discovery regarding Plaintiff's ownership and acquisition information, including but not limited to the ownership and/or acquisition of the Plaintiff or other similar practices ("Ownership and Acquisition Discovery") by TeamHealth Holdings, Inc. ("TeamHealth") are SUSTAINED, and the Court grants a protective order prohibiting Ownership and Acquisition Discovery.

Exhibit 2, October 19, 2020 Omnibus Order at ¶ 2, *Gulf-to-Bay Anesthesia Associates, LLC vs. Unitedhealthcare of Florida, Inc., et al.* The FL state court order on this point is persuasive here because it accurately reflects that a company's structure can have no logical bearing on the Health Care Providers' claims that include assertions that United is manipulating reimbursement data and failing to pay market rates. Requests for corporate structure information, costs and hospital contracts – like United's earlier request for clinical records – have no relationship to the First Amended Complaint's allegations, or any viable defense. The Court made it clear that "the relevant inquiry in this action is the proper rate of reimbursement which is based on the amount billed by the Health Care Providers and the amount paid by United." October 26, 2020 Order Denying Defendants' Motion To Compel Production Of Clinical Documents For The At-Issue Claims And Defenses And To Compel Plaintiff To Supplement Their NRCP 16.1 Initial Disclosures On An Order Shortening Time at ¶ 18.[2] Nothing else is relevant and United's attempt to expand this case and saddle the Health Care Providers with 155 categories of document requests is only to facilitate its desired delay.

Likewise, United points to a data matching protocol first proposed by the Health Care Providers on February 10, 2020 as a basis for needing an extension. This issue remains outstanding only because United has not participated in discovery in good faith. *See, e.g.* October 27, 2020 Order at ¶ 9. The Health Care Providers have not been able to agree because United has continually sought to limit discovery, limit custodians and obstruct access to legitimate discovery. *See, e.g.* September 28, 2020 Order at ¶ 15 ("The Court further finds that

[2] The Court also ruled that clinical records are not relevant to the action. *Id.*



McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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the protocol proposed by United in its Motion would unreasonably hamper the Health Care Providers from obtaining information with regard to the identity of custodians and information which would otherwise be discoverable."). No less important, United references the parties' inability to reach an agreed upon ESI protocol as a basis for why discovery was not completed and essentially admits that it has failed to produce discovery because "an agreement is needed to expedite discovery and reduce the burden on both sides." Motion at 11:12-13. Yet, the Court previously ordered "that discovery shall not be stayed pending completion of an ESI Protocol ***and all parties must comply with their discovery obligations during the pendency of negotiations concerning an ESI Protocol***." September 26, 2020 Order at 6:15-17 (emphasis added). All of these arguments are reminiscent of United's initial position that fact discovery should span a full year, followed by another 90 days of expert discovery. *See* JCCR at 20:24-25. Since the beginning, United has done everything in its power to disregard the Court's discovery ruling.

United also tries to take advantage of the Court's earlier order directing United to produce claims records, saying now it will take eleven more months to complete production. Motion at 11:15-16. The Health Care Providers imagine the next step will be United's request to extend discovery eleven more months to accommodate their slow-production on administrative records.

United also argues that expert discovery should be extended because "the discovery that United's experts must review in order for United to establish its defense must be completed in the coming months, and cannot be completed by the present initial expert disclosure deadline[]" of January 29, 2021. Motion at 11:21-23. This is misleading as United was required to produce all documents related to its affirmative defenses by November 6, 2020 and United provides the Court no explanation as to what it could possibly need from the Health Care Providers to establish any of its defenses. November 9, 2020 Order Setting Defendants' Production & Response Schedule Re: Order Granting Plaintiffs' Motion To Compel Defendants' List Of Witnesses, Production Of Documents And Answers To Interrogatories On Order Shortening

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966



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Time at ¶ 3(c). Without providing a link between what information it needs and why, United's carte blanche request to extend all other discovery deadlines is unsupported by good cause.

**B. United's Conduct Should Not Place the August 2, 2021 Trial Setting in Jeopardy**

United's request to continue the August 2, 2021 trial setting does not meet the requirements of EDCR 7.30(a), which provides:

> Any party may, for good cause, move the court for an order continuing the day set for trial of any cause. A motion for continuance of a trial must be supported by affidavit except where it appears to the court that the moving party did not have the time to prepare an affidavit, in which case counsel for the moving party need only be sworn and orally testify to the same factual matters as required for an affidavit. Counter-affidavits may be used in opposition to the motion.

Here, United's apparent good cause is predicated on its desire to unnecessarily push the expert deadline from April 19 to July 13, 2021. Motion at 4:1-3. This does not provide the sufficient good cause necessary given that it is United's maneuvering that has led to this situation. However, if the Court is inclined to adjust the trial date, the Health Care Providers respectfully request that the Court consider compressing the dispositive motion deadline, status check and calendar call and consider a firm trial setting at the Court's convenience, while trying to prevent any further prejudice to the Health Care Providers due to United's discovery tactics.

## III. CONCLUSION

For the foregoing reasons, the Health Care Providers respectfully request that this Court deny United's request to extend all non-fact discovery deadlines and deny United's request to continue the August 2021 trial setting.

DATED this 21st day of December, 2020.

McDONALD CARANO LLP

By: */s/ Kristen T. Gallagher*
Pat Lundvall (NSBN 3761)
Kristen T. Gallagher (NSBN 9561)
Amanda M. Perach (NSBN 12399)

*Attorneys for Plaintiffs*

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966



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**CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 21st day of December, 2020, I caused a true and correct copy of the foregoing **PLAINTIFFS' OPPOSITION TO MOTION TO EXTEND DISCOVERY DEADLINES AND CONTINUE TRIAL SETTING ON ORDER SHORTENING TIME** to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

D. Lee Roberts, Jr., Esq.
Colby L. Balkenbush, Esq.
Brittany M. Llewellyn, Esq.
WEINBERG, WHEELER, HUDGINS,
GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
lroberts@wwhgd.com
cbalkenbush@wwhgd.com
bllewellyn@wwhgd.com

Natasha S. Fedder
O'MELVENY & MYERS LLP
400 South Hope Street, 18th Floor
Los Angeles, CA 90071-2899
nfedder@omm.com

*Attorneys for Defendants*

/s/ *Marianne Carter*
An employee of McDonald Carano LLP

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966



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# EXHIBIT 1

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EXHIBIT 1

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*

**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,

vs.

UNITEDHEALTH GROUP, INC., a Delaware corporation; 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; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20,

Defendants.

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

**KRISTEN T. GALLAGHER DECLARATION IN SUPPORT OF PLAINTIFFS' OPPOSITION TO MOTION TO EXTEND DISCOVERY DEADLINES AND CONTINUE TRIAL SETTING ON ORDER SHORTENING TIME**

I, KRISTEN T. GALLAGHER, declare as follows:

1. I am an attorney licensed to practice law in the State of Nevada and am a partner in the law firm of McDonald Carano LLP, counsel for plaintiffs Fremont Emergency Services



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(Mandavia), Ltd. ("Fremont"); Team Physicians of Nevada-Mandavia, P.C. ("Team Physicians"); Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine ("Ruby Crest" and collectively the "Health Care Providers").

2. This declaration is submitted in support of the Health Care Providers' Opposition To Motion To Extend Discovery Deadlines And Continue Trial Setting On Order Shortening Time and is made of my own personal knowledge, unless otherwise indicated. I am over 18 years of age, and I am competent to testify as to same.

3. United's lack of diligence and participation resulted in the Health Care Providers proposing a 60-day extension of the fact discovery deadline only. United responded with a 90-day proposal of all discovery deadlines, but did not make any reference to the trial date, stating: "Please let us know if you are agreeable to a 90-day extension of all discovery deadlines."

4. In an effort to compromise, the Health Care Providers offered to split the difference and proposed a 75-day fact discovery extension, but communicated that they are not amendable to extension of any other discovery deadline.

5. On December 7, 2020, in response to United's letters regarding the Health Care Providers' discovery responses, I responded to United's counsel with a request to discuss telephonically.

I declare under penalty of perjury that the foregoing is true and correct.

Executed: December 21, 2020.

/s/ *Kristen T. Gallagher*
Kristen T. Gallagher

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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# EXHIBIT 2

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EXHIBIT 2

IN THE CIRCUIT COURT FOR THE
THIRTEENTH JUDICIAL CIRCUIT IN AND
FOR HILLSBOROUGH COUNTY, FLORIDA

GULF-TO-BAY ANESTHESIOLOGY ASSOCIATES, LLC,

*Plaintiff,*

v.

UNITEDHEALTHCARE OF FLORIDA, INC., and UNITEDHEALTHCARE INSURANCE CO.,

*Defendants.*

CASE NO.: 17-CA-011207

_____/

**[PROPOSED] OMNIBUS ORDER ON PENDING DISCOVERY ISSUES**

THIS CAUSE came before the Court for hearing on September 24, 2020, upon the following Objections and Motions: (A) Plaintiff's Objection to Notice of Intent to Serve Subpoena Duces Tecum to Non-Party TeamHealth Holdings, Inc., (B) Plaintiff's Objection to Notice of Intent to Serve Subpoena Duces Tecum to Non-Party Collect Rx, Inc. (A and B are collectively referred to as the "Objections"), (C) Defendants' Motion to Compel Discovery Filed on August 21, 2020, and (D) Defendants' Motion to Compel Supplemental Responses to Plaintiff's First Set of Interrogatories (C and D are collectively referred to as the "Motions"). The Court having considered the Objections and Motions, having considered Plaintiff's Omnibus Response to the Motions, having considered Defendants' response to the Objections, having heard the arguments of counsel, having reviewed the pleadings and the Court file, and being otherwise fully advised in the premises.

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It is therefore hereby **ORDERED AND ADJUDGED** as follows**:**

1. The following rulings apply to both party discovery and third party discovery ("Discovery") as follows:

2. The Objections to Discovery regarding Plaintiff's ownership and acquisition information, including but not limited to the ownership and/or acquisition of the Plaintiff or other

similar practices ("Ownership and Acquisition Discovery") by TeamHealth Holdings, Inc. ("TeamHealth") are SUSTAINED, and the Court grants a protective order prohibiting Ownership and Acquisition Discovery. As set forth in the transcript of the Hearing, this ruling is without prejudice to the Defendants to seek further order or relief as discovery proceeds if something changes or if there is something that, significantly, comes up for the Court to re-address.

3. The timeframe for Discovery is limited to 2017 forward.

4. The geographic scope for Discovery is the State of Florida.

5. The service lines for Discovery are limited to anesthesia services provided by Plaintiff as reflected on its chargemasters and the Disputed Commercial Claims at issue in the litigation.

6. Discovery shall not include payments from Medicare and Medicaid. Except as set forth in paragraph 7 below, Discovery will include payments from other payers.

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7. The Court reserves ruling on the questions of (1) whether Discovery will include Medicare Advantage and Managed Medicaid; and (2) Plaintiff's cost information. The parties will submit supplemental filings regarding these two questions for the Court's consideration and determination.

**DONE AND ORDERED** in Chambers, in Hillsborough County, Florida this _____ day of _____, 2020.

Electronically Conformed 10/19/2020
Christopher Sabella
The Honorable Christopher C. Sabella
Circuit Judge

Copies furnished to all counsel of record.

# EXHIBIT 11

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EXHIBIT 11

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**From:** Balkenbush, Colby
**Sent:** Tuesday, December 29, 2020 3:03 PM
**To:** Kristen T. Gallagher; Amanda Perach
**Cc:** Pat Lundvall; Roberts, Lee; Llewellyn, Brittany M.; Fedder, Natasha S.; Genovese, Amanda L.; Portnoi, Dimitri D.; Blalack II, K. Lee
**Subject:** Continued Meet and Confer Re Plaintiffs' Discovery Deficiencies (Fremont v. UHC)

Amanda and Kristy,

As a follow up to our last telephonic conferral, below, please find (1) United's request priority list for our next conferral and (2) notes related to the discovery requests we discussed.

1) United's request priority list. Each of these requests are detailed in United's 11/17 letter concerning Plaintiffs' Responses to Defendants' Second Set of Requests. During the next conferral, we need you to let us know (1) whether Plaintiffs will be supplementing their responses/productions to the specific document requests listed below, and (2) and if they will do so **by 12/31**.

   - Document requests related to Plaintiffs' billing practices (Request Nos. 45, 46, 47, 48, 62, 63, 64, 65, 66, 67, and 80), which are discussed on pages 6 and 7 of our 11/17 conferral letter.
     - For Requests Nos. 45, 46, 47, and 48, Plaintiffs have supplemented their initial responses by producing one or more of the *same three documents* for each Request.
       - Those documents are: a one-page fee schedule policy summary (FESM001390); a one-page managed care rate approval policy summary (FESM001475); and a spreadsheet of claims data (FESM001456).
       - These responses still appear to be deficient, because the Requests seek "*all documents*

reflecting" Plaintiffs' "discussions, deliberations and/or decisions regarding setting, adjusting, and/or maintaining the rates, and each and every component thereof, for each CPT code charged in the Claims" (No. 45); Plaintiffs' "decisions to set, adjust (or keep constant) the rates charged, and each and every component thereof, for any of the CPT codes related to the Claims" (No. 55); "any 'charge masters' that were used by you that represent your full billed charges for any of the CPT codes related to the Claims from July 1, 2017 to the present" (No. 47); and "which you considered from external sources when setting, adjusting (or keeping constant), the rates charged for any of the CPT codes related to the Claim" (No. 48).

  - For Requests Nos. 62, 63, 64, 65, 66, 67, and 80, Plaintiffs declined to respond in their initial production of September 28, 2020, and did not provide any supplemental response in their supplemental production of November 21, 2020.

- Document requests related to audits of Plaintiffs' billing practices (Request Nos. 73, 74, 75, and 76), which are discussed on page 8 of our 11/17 conferral letter.
  - For these Requests, Plaintiffs declined to respond in their initial production of September 28, 2020, and did not provide any supplemental response in their supplemental production of November 21, 2020.
- Document requests relating to "the comparison of Plaintiffs' billed charges for emergency medical services to the reimbursement rates you have agreed to accept by contract from Payers other than Defendants from July 1, 2017 to present" (Request No. 99), which is discussed on pages 10 and 11 of our 11/17 conferral letter.
  - For this Request, Plaintiffs declined to respond in their initial production of September 28, 2020, and did not provide any supplemental response in their supplemental production of November 21, 2020.

2) Can you please confirm **by 3:00PM PT on 12/31** whether Plaintiffs are producing documents for the over 20 document requests where Plaintiffs' previous stated that they would produce non-privileged responsive documents after the Court's adjudication of United's Renewed Motion to Stay Proceedings Pending Resolution of Writ Petition on Order Shortening Time? Those are Request Nos. 27, 28, 31, 34, 35, 44, 54, 55, 56, 87, 88, 110, 112, 114, 116, 122, 123, 139, 141, 148, 152, and 153, which we listed on the call. It has been several months since the Court's order. If responses are not supplemented **by 1/5/21**, Defendants will be filing a motion to compel and consider the meet and confer process on this particular issue to be complete.

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3) Notes from our last conferral (12/11).

- Plaintiffs are producing market data this week -- Plaintiffs suggested they would "try to do it before the holidays," which have already passed. Defendants would like to avoid court intervention on this particular issue, so please produce the market data as soon as possible.
- Plaintiffs are "getting back to us" regarding certain document requests in United's 12/4 letter. For our next conferral, we need you to let us know (1) whether Plaintiffs will be supplementing their responses/productions to the specific document requests listed below, and (2) and if they will do so **by 12/31**.
  - Request No. 13 (discussed on page 2);
  - Request No. 17 (discussed on page 3 United's 12/4 letter); and
  - Request No. 22 (discussed on pages 3 and 4 of United's 12/4 letter).
- For document requests "relating to the corporate structure of TeamHealth Holdings" and requests "related to the Health Care Providers' costs of doing business and contracts between the Health Care Providers and the hospitals where they provide emergency services," United considers the parties to be at an impasse as to whether such information is discoverable and relevant to Plaintiffs' claims and/or United's defenses. *See* Plaintiffs' Opposition to Motion to Extend Discovery Deadlines and Continue Trial Setting on Order Shortening Time (""Requests for corporate structure information, costs and hospital contracts – like United's earlier request for clinical records – have no relationship to the First Amended Complaint's allegations, or any viable defense."). Plaintiffs' statements in their opposition were consistent with the discussion during our last conferral.

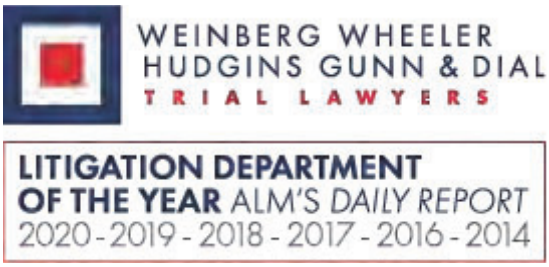
Please note that the above is not an exhaustive list of the discovery requests that United seeks to discuss with Plaintiffs related to deficiencies in both Plaintiffs' responses and productions. However, due to the volume of deficiencies

identified in United's 11/17 and 12/4 letter, we believe it is most efficient to discuss the discovery deficiencies in batches.

Please let us know your availability for a call tomorrow, 12/30, or Thursday, 12/31, to discuss the issues identified in this email.

Best,

Colby




Colby Balkenbush, Attorney
**Weinberg Wheeler Hudgins Gunn & Dial**
6385 South Rainbow Blvd. | Suite 400 | Las Vegas, NV 89118
D: 702.938.3821 | F: 702.938.3864
www.wwhgd.com | vCard

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# EXHIBIT 12



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EXHIBIT 12

**UNITED STATES DISTRICT COURT**
**EASTERN DISTRICT OF TENNESSEE**

**CELTIC INSURANCE COMPANY**,

Plaintiff,

v.

**TEAM HEALTH HOLDINGS, INC. and AMERITEAM SERVICES, L.L.C.**,

Defendants.

Civil Action No. _____

**COMPLAINT**

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Plaintiff Celtic Insurance Company ("Celtic"), on personal knowledge as to information within its possession and on information and belief as to all other matters, alleges as follows against Defendants Team Health Holdings, Inc. and AmeriTeam Services, L.L.C. (collectively, "TeamHealth"):

## NATURE OF THE ACTION

1. In the past seven years, TeamHealth billed over $100,000,000 in fraudulent health insurance claims to Affordable Care Act health insurance plans run by Celtic. TeamHealth perpetrated this billing fraud by "upcoding" tens of thousands of health insurance claims, then submitting the upcoded claims to Celtic under the names of thousands of unsuspecting doctors who work for TeamHealth. TeamHealth kept the profits from the fraud that it perpetrated in the doctors' names. TeamHealth's fraud harmed patients, the doctors who work for it, and Celtic. It also harmed Affordable Care Act insurance and put upward pressure on healthcare costs for millions of Americans. In this action, Celtic seeks to protect its members and Affordable Care Act insurance, and recover damages and penalties for TeamHealth's substantial, systematic, and sustained health insurance fraud against Affordable Care Act insurance.

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2. TeamHealth is one of the largest emergency room ("ER") staffing, billing, and collections companies in the United States. TeamHealth is under investigation by the United States Congress for "surprise billing" and suing patients;[1] is being sued in a qui tam action on behalf of the Centers of Medicare and Medicaid Services for fraudulent upcoding;[2] is being sued by other

[1] *See* Letter from Frank Pallone, Jr., Chairman, H. Comm. on Energy and Commerce, et al. to Leif M. Murphy, TeamHealth CEO, regarding a Congressional investigation into TeamHealth's "surprise billing" practices (Dec. 19, 2019), https://republicans-energycommerce.house.gov/wp-content/uploads/2019/12/TeamHealth.2019.12.19.-Letter-Surprise-Billing.OI-PRESS.pdf.

[2] *See United States ex rel. Hernandez v. Team Health, Inc.*, No. 2:16-CV-00432-JRG, 2020 WL 731446 (E.D. Tex. Feb. 13, 2020) (order denying TeamHealth's motion to dismiss).



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health insurance companies for fraudulent upcoding;[3] and is being sued in a class action for sending fraudulent bills to patients.[4]

3. TeamHealth has submitted more than 250,000 health insurance claims to Celtic in the past seven years. Celtic is an insurance company that offers Affordable Care Act health insurance in 20 states. Celtic has determined that a material portion of those 250,000-plus health insurance claims were fraudulently upcoded, meaning TeamHealth submitted insurance claims for more expensive services than its doctors and physician's assistants actually provided to Celtic's members.

4. TeamHealth's business model is to convince hospitals to replace local ER practice groups with TeamHealth's national outsourcing enterprise. TeamHealth then staffs the emergency departments with ER doctors and physician's assistants under contract with TeamHealth (hereinafter "healthcare contractors"), and it bills insurance companies and patients for the services that its healthcare contractors provide.

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5. After TeamHealth's healthcare contractors provide a service to a patient, an administrative group at TeamHealth's corporate offices creates a health insurance claim by converting the medical record created by TeamHealth's healthcare contractors into a health insurance claim. Then TeamHealth sends the claim to an insurance company, if applicable, or to

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[3] *See*, *e.g.*, UnitedHealth Group's counterclaim in *Emergency Care Services of Pennsylvania et al. v. UnitedHealth Group et al.*, Case No. 5:20-cv-5094 (E.D. Pa.), ECF No. 37 (explaining that TeamHealth engaged in upcoding on health insurance claims that TeamHealth submitted to United).

[4] *See* Class Action Complaint in *Fraser v. Team Health Holdings, Inc.*, Case No. 20-4600, at ¶ 6 (N.D. Cal. July 10, 2020) ("The TeamHealth Fraudulent Billing Enterprise maximizes its profits by sending fraudulent bills to patients for the care they receive from TeamHealth physicians. TeamHealth has inflated the rates it charges patient-consumers far above those that it knows it is legally entitled to collect from those patients.").



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CMS or the patient. TeamHealth's healthcare contractors on the front-line do not see the insurance claims that TeamHealth creates, even though the claim is submitted in their name. Nor do TeamHealth's front-line healthcare workers receive the money that TeamHealth collects on its health insurance claims—TeamHealth requires the money to be sent directly to TeamHealth. For the most part, TeamHealth classifies its doctors and physician's assistants as "independent contractors" and pays them a fixed hourly fee. Using this scheme, TeamHealth is able to keep most of the money that its doctors and physician's assistants generate.

6. Insurance companies do not see the medical records generated by TeamHealth's healthcare contractors. Instead, TeamHealth typically only sends medical billing codes and minimal other data to insurance companies, like Celtic. This information asymmetry is ripe for fraud, and TeamHealth has exploited it.

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7. In the past seven years, TeamHealth has submitted over 250,000 health insurance claims to Celtic. Celtic has paid TeamHealth's claims in reliance on the medical billing codes submitted by TeamHealth. TeamHealth has systematically inflated the medical billing codes on a large portion of the insurance claims that it submitted to Celtic by using three schemes.

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8. ***First*, TeamHealth systematically engages in classic medical "upcoding."** In the healthcare provider industry, an illegal profit-maximization strategy is to "upcode" medical billing codes on health insurance claims. Upcoding is billing for a more expensive medical service than actually was provided. By upcoding, a healthcare provider like TeamHealth can inflate its health insurance claims and receive more money. Evidence shows that TeamHealth systematically engages in this illegal practice.

9. Medical claims coding is the process of converting medical records into standardized medical codes for billing purposes. These standardized codes are then used to bill



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for medical services. Medical billing codes are referred to as Current Procedural Terminology ("CPT") codes. Once TeamHealth takes over a local hospital's ER department, TeamHealth handles all of the medical coding work for the ER department, and TeamHealth submits the codes to insurance companies as health insurance claims.

10. TeamHealth systematically upcodes health insurance claims that it submits to Celtic, using higher medical billing codes than appropriate for the services provided. TeamHealth keeps the excess collections for itself as corporate profits; the doctors and physician's assistants who actually performed the work do not receive the excess payments because, in general, they are paid a fixed hourly rate.

11. TeamHealth's fraud was discovered in separate litigation, when Celtic moved to compel medical records from TeamHealth associated with a subset of the health insurance claims that TeamHealth put at issue in that case. TeamHealth resisted Celtic's request that TeamHealth produce actual medical records—but the court ordered TeamHealth to produce them. Celtic reviewed a sample of the medical records, and determined that TeamHealth systematically upcoded health insurance claims that TeamHealth billed at the highest and most expensive ER code.[5] Celtic determined that TeamHealth billed routine services that TeamHealth's healthcare contractors provided at the highest ER medical billing codes—99285 and 99284—even when the patients required only straightforward and brief treatment or monitoring. For example, patients complaining of headaches, fevers, bug bites, and other relatively minor symptoms resulted in health insurance claims billed at the most expensive ER billing codes.

12. Similarly, one of Celtic's affiliates recently received and reviewed more than 10,000 of TeamHealth's medical records associated with health insurance claims that TeamHealth

[5] ER billing codes are described in detail *infra* note 25.



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billed at the highest ER medical billing codes. Celtic's affiliate concluded that TeamHealth had "upcoded" nearly two-thirds of the health insurance claims associated with those 10,000-plus medical records.

13. Health insurance claims data from the past 12 months illustrate the abnormal distribution of medical billing codes submitted by TeamHealth: other ER service providers typically bill Celtic the most-expensive ER billing code less than 30% of the time, while TeamHealth bills Celtic the most-expensive billing code 48% of the time.

14. TeamHealth has also billed Celtic for ER "critical care" CPT codes that are not warranted—and it has billed those codes at an unjustifiably high rate. Critical care CPT codes are reserved for rare situations in which there is a high probability of sudden, clinically significant, or life-threatening deterioration in the patient's condition, which requires the highest level of physician preparedness to intervene urgently. Critical care codes command a higher payment than even the most expensive standard ER code. TeamHealth has been sued for upcoding standard ER services to "critical care" billing codes in a qui tam case described below. In that case, a whistleblower detailed internal emails and presentations by TeamHealth executives encouraging TeamHealth employees to bill critical care codes:

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> "Just a reminder to **keep up the critical care billing!** Abnormal vital signs, ICU admits, blood transfusions, trauma activations, and IV ggts all warrant critical care. We are still missing some obvious opportunities . . . ."[6]

[6] As explained in the qui tam complaint, very few situations meet the CMS definition for "critical care," and CMS requires individualized assessment of each presenting condition to see whether it fulfills the criteria for critical care. *See* Second Amended Complaint at ¶¶ 8, 128, *United States ex rel. Hernandez v. Team Health, Inc.* (No. 2:16-CV-00432-JRG), 2020 WL 731446 (E.D. Tex. Sept. 19, 2019).



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15. TeamHealth's upcoded health insurance claims have caused Celtic to substantially overpay TeamHealth for services performed by its doctors and physician's assistants. By upcoding, TeamHealth has submitted thousands of fraudulent insurance claims to Celtic, resulting in substantial overpayments from Celtic that TeamHealth secured through fraud. This fraud is ongoing.

16. ***Second*, TeamHealth systematically bills for services provided by physician's assistants as if the service were provided by a doctor.** Medicaid, Medicare, and private health insurance companies generally pay less for services provided by physician's assistants than for services provided by doctors. Of the 250,000-plus health insurance claims that TeamHealth submitted to Celtic, TeamHealth represented to Celtic that one of its doctor-contractors performed the service nearly 100% of the time. An analysis of millions of ER insurance claims, however, shows that normally a doctor provides ER services only 82% of the time, and a physician's assistant provides the ER service the remaining 18% of the time.[7]

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17. In separate litigation, Celtic moved to compel and received medical records from TeamHealth for a subset of the health insurance claims that TeamHealth submitted to Celtic. Based on Celtic's review of those medical records, Celtic determined that TeamHealth regularly submitted claims to Celtic indicating that one of TeamHealth's doctor-contractors provided the service to the member, when in fact one of its physician's assistants did. By making these misrepresentations to Celtic, TeamHealth has submitted thousands of fraudulent insurance claims to Celtic, resulting in substantial payments from Celtic at "doctor rates" that TeamHealth secured through fraud. This fraud is ongoing.

[7] *See* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Physician-and-Other-Supplier (CMS payment data).



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18. ***Third*, TeamHealth uses an out-of-network strategy to try to collect many times the amount owed for the services that its healthcare contractors provide.** The harm from TeamHealth's upcoding schemes is exacerbated because TeamHealth uses an "out-of-network strategy" in an effort to collect its sticker price rates, otherwise known as "billed charges," on its upcoded claims. TeamHealth sets these billed charges at amounts that often are seven, eight, or nine times the amount described in the ACA regulations for the relevant services.[8]

19. Because TeamHealth acts as an intermediary between its healthcare contractors and insurance companies, TeamHealth decides whether its healthcare contractors will be "in-network" with a particular insurance plan, or operate without a contract with the insurance company and thus be "out-of-network." To maximize profits, TeamHealth often pursues an "out-of-network strategy," opting not to contract with insurance companies at reasonable rates, and instead trying to bill for extremely high "billed charges," which TeamHealth unilaterally sets. TeamHealth uses these exorbitant billed charges to inject inappropriate costs into the healthcare system, and it has even sued patients and insurance companies to collect on these exorbitant charges, which bear no resemblance to the cost of providing the service. TeamHealth often uses the threat of litigation to attempt to squeeze more out of insurance plans like the Affordable Care Act insurance plans offered by Celtic.

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20. TeamHealth's billing schemes demonstrate the risk of allowing national outsourcing companies like TeamHealth to take over local doctor-run ER departments. Because of this risk, many states bar corporations from practicing medicine or employing physicians.

[8] The Affordable Care Act anticipated that people with ACA insurance would from time-to-time see out-of-network ER providers. The ACA regulations require that ACA insurance pay out-of-network ER providers no less than the "greatest of three" different measures: (i) the amount paid to in-network ER providers; (ii) the amount typically paid to out-of-network ER providers; or (iii) the amount paid by Medicare. 29 C.F.R. § 2590.715–2719A(b)(3).



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TeamHealth has created a complex corporate structure in an effort to avoid these laws and disguise its actions. TeamHealth's actions exploit the risks that the laws were designed to avoid.

21. The higher payments that TeamHealth has extracted through its billing schemes create upward pressure on insurance premiums and can result in high out-of-pocket costs for patients. This case involves Affordable Care Act insurance, which is designed for those who often cannot afford traditional health insurance. TeamHealth's upcoding schemes harm patients, Celtic and its members, and taxpayers.[9]

**PARTIES**

22. Plaintiff Celtic Insurance Company ("Celtic" or "Plaintiff") offers health insurance pursuant to the Affordable Care Act, and it pays insurance claims submitted by providers under those policies. Celtic is a subsidiary of Centene Corporation ("Centene"), a publicly traded health insurance company that focuses on providing affordable insurance to uninsured, under-insured, and low-income individuals. Centene provides insurance through government-subsidized programs such as Medicare, Medicaid, and the Affordable Care Act. Celtic is an Illinois corporation, with its principal place of business in Illinois, and is therefore a citizen of Illinois.

23. Defendants are a system of affiliated entities operating as and collectively referred to herein as "TeamHealth." TeamHealth is owned by a large private equity firm. That private equity firm acquired TeamHealth in 2017 for $6.1 billion. TeamHealth primarily provides emergency room staffing and administrative services to hospitals through a network of subsidiaries, affiliates, and independent contractors, which operate in 47 states and which

[9] Certain of TeamHealth's affiliates sued Celtic regarding health insurance claims, and Celtic filed counterclaims against those affiliates, in Arkansas, Mississippi, Georgia, and Florida. With regard to the subset of insurance claims that are within the scope of those other cases, Celtic's damages in this case may be reduced by Celtic's recovery in those other cases.

TeamHealth refers to as the "TeamHealth System." TeamHealth designed the complex structure of the TeamHealth System to avoid state laws that prohibit general business corporations from practicing medicine, employing doctors, controlling doctors' medical decisions, and/or splitting professional fees with doctors (known as the "corporate practice of medicine").

24. Defendant Team Health Holdings, Inc. is a Delaware corporation with its principal place of business at 265 Brookview Centre Way, Suite 400, Knoxville, Tennessee 37919 and is therefore a citizen of Delaware and Tennessee.

25. Defendant AmeriTeam Services, L.L.C. is a Tennessee Limited Liability Company. Its sole member is Team Finance L.L.C., whose sole member is Team Health Holdings, Inc. AmeriTeam Services, L.L.C. employs the executive officers and administrative leaders of TeamHealth; issues the policies that govern all TeamHealth entities, in conjunction with its ultimate parent, Team Health Holdings, Inc.; and provides operational direction and administrative and support services to all TeamHealth entities. Its principal place of business is at 265 Brookview Centre Way, Suite 400, Knoxville, Tennessee 37919. Because AmeriTeam Services, L.L.C. takes the citizenship of its sole member's sole member, Team Health Holdings, Inc., it is likewise a citizen of the States of Delaware and Tennessee.

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26. Because the misconduct at issue in this case is the result of policies and practices issued, directed, and overseen by both Defendants jointly, and because both Defendants jointly control the "TeamHealth system," this Complaint refers to both Defendants collectively as "TeamHealth."

**JURISDICTION AND VENUE**

27. This Court has subject matter jurisdiction pursuant to 28 U.S.C. § 1331 and 18 U.S.C. § 1964(a) because Celtic's claim under the Racketeer Influenced and Corrupt Organizations Act ("RICO"), 18 U.S.C. §§ 1961 et seq., arises under federal law. This Court also



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has supplemental subject matter jurisdiction over Celtic's state-law claims pursuant to 28 U.S.C. § 1367 because those claims are so related to Celtic's federal-law RICO claim that they form part of the same case or controversy.

28. Additionally and in the alternative, this Court has subject matter jurisdiction pursuant to 28 U.S.C. § 1332 because Plaintiff and Defendants are completely diverse: Plaintiff is a citizen of Illinois, and Defendants are citizens of Delaware and Tennessee. The amount in controversy exceeds $75,000.

29. Venue is proper in this judicial district pursuant to 18 U.S.C. § 1965(a) because TeamHealth resides, is found, has agents, and transacts its affairs in this district. Venue is also proper under 28 U.S.C. § 1391(b)(1) and (2) because TeamHealth resides in this district and because events giving rise to this Complaint took place within this district.

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## FACTS

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### I. The Rise of TeamHealth and Outsourced, Out-of-Network Emergency Services

30. TeamHealth's business model is to convince local hospitals to "outsource" their emergency departments to TeamHealth. TeamHealth then staffs those emergency departments with doctors and physician's assistants who work for TeamHealth as "independent contractors." TeamHealth acts as an intermediary or gatekeeper between these healthcare contractors and the insurance companies that pay for their services.

31. By acting as an intermediary, TeamHealth gets to bill for services performed by its healthcare contractors.

32. TeamHealth's business model of being an intermediary between doctors and insurance companies causes doctors to be paid less. TeamHealth requires that all payments be sent directly to TeamHealth's corporate enterprise—and TeamHealth keeps most of the payments. TeamHealth generally compensates its healthcare contractors at a fixed hourly rate that does not



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vary with the amount of excess payments TeamHealth extracts through its fraudulent billing schemes.

33. TeamHealth has blocked Celtic's attempt to negotiate with and enter into agreements directly with the front-line ER doctors who provide services to Celtic's members. Such agreements likely would result in more compensation going directly to the front-line ER doctors and medical workers for services they provide to Celtic's members.

34. TeamHealth uses a variety of schemes to inflate its bills, and then it aggressively collects on its bills.

35. Because TeamHealth controls whether its healthcare contractors are in-network or out-of-network, its individual healthcare contractors cannot decide that question for themselves, and they have no say in how much TeamHealth bills for their services. Thus, TeamHealth—and TeamHealth alone—is the controlling intermediary between its healthcare contractors, on the one hand, and health insurance companies and patients, on the other.

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36. TeamHealth's business model has generated significant profits. Over the past four decades, TeamHealth has grown dramatically by acquiring other staffing/billing companies focused primarily on emergency services. It has become "one of the largest suppliers of outsourced healthcare professional staffing and administrative services to hospitals and other healthcare providers in the United States."[10] TeamHealth now operates nationwide, claiming to control hospital ER departments in 47 states, and employing more than 18,000 healthcare contractors.[11]

[10] TeamHealth Annual Report (Form 10-K) (Feb. 22, 2016), https://www.sec.gov/Archives/edgar/data/1082754/000108275416000054/tmh-201510k.htm.

[11] *Id.*



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37. When TeamHealth takes over a hospital's emergency department, it demands to negotiate with insurance companies directly—without involving the hospital in which TeamHealth is working. TeamHealth often opts to be "out-of-network" with an insurance company, even when the hospital where its doctors work is in-network. TeamHealth is able to do this without reducing the volume of patients treated by its doctors, because patients typically do not select their ER doctors or know that the ER doctor may be out-of-network, especially when the ER doctor works at an in-network hospital. As a result, TeamHealth can refuse to join an insurer's network, and can charge higher out-of-network rates with little risk of losing business. TeamHealth can in turn use the threat of staying out-of-network to demand that an insurance company pay higher rates to have TeamHealth's doctors in-network.

38. According to a recent study on out-of-network ER physicians: "[W]hen TeamHealth receives a new hospital contract, physicians working for the firm go out-of-network for several months and then rejoin[s] networks while using the now credible threat of out-of-network status to secure higher in-network payments."[12] The study found that when TeamHealth rejoins the network, it receives in-network rates that are 68% higher than they were before TeamHealth took over the ER department.[13]

39. As a result of its strategy, TeamHealth extracts from private insurers on average 364% of the rates allowed by Medicare.[14] For comparison, the same study found that in-network ER departments typically receive on average 266% of the Medicare rates, internists 158% of

[12] Zack Cooper, et al., *Surprise! Out-of-Network Billing for Emergency Care in the United States*, at 4–5, 23 (Dec. 2018).

[13] *Id.* at 36.

[14] *Id.* at 25.



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Medicare rates, and orthopedists 178% of Medicare rates.[15] Each year, the Centers for Medicare & Medicaid Services ("CMS") revises its Medicare fee schedule, which is a schedule of payments that Medicare pays for each CPT code. The Medicare fee schedule is a widely used benchmark for payments in the healthcare industry.

40. Instead of leaving and then rejoining an insurance company's network, TeamHealth may instead choose to stay out-of-network, and bill extremely high "billed charges"—often 800%, 900%, or 1000% the rate allowed by Medicare—and then attempt to collect those high charges from patients and insurance companies.

41. When TeamHealth is out-of-network, the insurer almost never pays TeamHealth's "billed charges" in full because those charges are not commercially reasonable and are often ten or more times the cost of the service performed by TeamHealth's healthcare contractor. After collecting a portion of its "billed charges" from the insurance company, TeamHealth may then try to collect from the patient the difference between TeamHealth's "billed charges" and the insurer's payment. The patient—who likely did not even know that the ER doctor or physician's assistant worked for TeamHealth and was out-of-network—then receives a "surprise bill" for emergency services from one of TeamHealth's affiliates.

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42. When sending bills or providing services, TeamHealth usually does not use its name; instead, it uses the names of its doctors or one of dozens of affiliates, most of which do not carry the TeamHealth name. Because TeamHealth uses many different entities and names to carry out its billing scheme, it has been able to mask the enormity of its enterprise and the sheer number of times it has carried out this scheme.

[15] *Id.*



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43. TeamHealth has aggressively pursued litigation against patients who are unable to pay TeamHealth's extremely high "billed charges." For example, between 2017 and 2019, TeamHealth filed more than 4,800 lawsuits against patients in Tennessee state courts.[16] TeamHealth has also sued thousands of patients in other states. And TeamHealth has filed 38 lawsuits since 2018 against health insurance companies, demanding higher payments for out-of-network services rendered by TeamHealth healthcare contractors.[17] To protect its out-of-network "surprise billing" scheme, TeamHealth has funded a front group that spent $28 million on lobbying against legislation that would protect patients from TeamHealth's surprise bills.[18]

44. The collateral damage caused by TeamHealth's efforts to maximize profits under its business model is higher healthcare costs for Americans in the form of higher insurance premiums, increased member cost-sharing, more tax subsidies, and thousands of lawsuits clogging the court system and jeopardizing the finances of American families.

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## II. The Corporate Practice of Medicine in Disguise.

45. TeamHealth structures its business operations to support its profit-maximizing strategy while disguising its participation in the corporate practice of medicine. The corporate practice of medicine doctrine "prohibits corporations from practicing medicine or employing a

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[16] Wendi C. Thomas, et al., *A Private Equity-Owned Doctors' Group Sued Poor Patients Until It Came Under Scrutiny*, Nat'l Pub. Radio (Nov. 27, 2019), https://www.npr.org/sections/health-shots/2019/11/27/783449133/a-private-equity-owned-doctors-group-sued-poor-patients-until-it-came-under-scru.

[17] Isaac Arnsdorf, *How Rich Investors, Not Doctors, Profit from Marking Up ER Bills*, ProPublica, (June 12, 2020), https://www.propublica.org/article/how-rich-investors-not-doctors-profit-from-marking-up-er-bills.

[18] Margot Sanger Katz et al., *Mystery Solved: Private-Equity-Backed Firms Are Behind Ad Blitz on "Surprise Billing."* N.Y. Times (Sept. 13, 2019), https://www.nytimes.com/2019/09/13/upshot/surprise-billing-laws-ad-spending-doctor-patient-unity.html.



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physician to provide professional medical services."[19] This rule promotes doctors working for themselves or with other doctors. It is intended to safeguard against the "commercialization of the practice of medicine," a divergence between a company's obligations to maximize profits for shareholders and a physician's obligations to patients.[20] At bottom, the corporate practice of medicine risks putting financial incentives above patient care.

46. TeamHealth tries to circumvent state laws banning the corporate practice of medicine by creating and maintaining a large number of subsidiaries with various names.[21] TeamHealth owns and operates a number of regional corporations, which in turn own subsidiary companies that employ physicians, often purportedly as "independent contractors." TeamHealth, the corporation, thus avoids directly employing doctors. In Texas, for instance, doctors working for TeamHealth are independent contractors to a professional association or P.A., which is affiliated with TeamHealth but purportedly is owned by a doctor.[22] But, according to one report, that doctor is in fact an executive at TeamHealth whom the company can remove and replace at any time.[23]

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47. At its headquarters, TeamHealth handles all of the medical coding and billing for work performed by its healthcare contractors around the country, and it does so using uniform procedures across the enterprise designed to maximize revenue. It centrally controls its healthcare

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[19] *Issue Brief: Corporate Practice of Medicine*, Am. Med. Ass'n (2015), https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/arc/corporate-practice-of-medicine-issue-brief_1.pdf.

[20] *Id.*

[21] Arnsdorf, *supra* note 17.

[22] *Id.*

[23] *Id.*



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contractors nationwide by setting procedures for their work, dictating when and how much they work, and determining what its healthcare contractors are paid, which usually is a fixed hourly rate. And TeamHealth centrally decides what "code" to assign and how much to bill for its healthcare contractors' services.

48. When TeamHealth's healthcare contractors complete their work with a patient, they submit medical records to TeamHealth's headquarters, where the next step of TeamHealth's scheme occurs: upcoding, overbilling, and aggressively collecting money beyond what is owed.

## III. TeamHealth's Scheme of Systematic Upcoding and Overbilling.

49. TeamHealth has systematically inflated health insurance claims that it has submitted to Celtic over the past seven years through various schemes: classic upcoding; billing for services by physician's assistants under a doctor's name; and billing for services at a price that is eight, nine, or ten times the price allowed by Medicare.

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### A. Classic Upcoding: Billing for More Expensive Services than Were Actually Provided.

50. Coding is the process of converting a medical record into a billing code that accurately describes the medical service provided. Billing codes are used by insurance companies and CMS to pay for medical services. Standardized health care billing codes are called Current Procedural Terminology ("CPT") codes. TeamHealth determines what CPT code to bill and sends claims containing these codes to insurance companies and CMS when TeamHealth seeks payment for services. When seeking payment for services, TeamHealth typically does not provide actual medical records to insurance companies or CMS. Instead, TeamHealth makes a representation to the insurance company or CMS that the CPT codes accurately describe the service provided by the TeamHealth contractor.



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51. Upcoding occurs when a healthcare provider submits a health insurance claim with a CPT code that corresponds to a more expensive service than was actually provided. The higher code triggers a greater payment. Upcoding is health insurance fraud.[24]

52. Emergency medical services are typically billed using one of five CPT codes: 99281, 99282, 99283, 99284, and 99285, with the last digit representing the level of severity.[25]

[24] Medical Learning Network, *Medicare Fraud & Abuse: Prevent, Detect, Report* (Feb. 2019), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf.

[25] CPT Codes 99281–99285 are used to "code" and bill standard emergency department services. CPT Codes 99291–99292 are used to code and bill "critical care" ER services. American Medical Association, *CPT 2020 Professional Edition* 22-23 (Mark S. Synovec et al. eds., 2020) (content also available at https://www.ama-assn.org/system/files/2020-05/telehealth-services-covered-by-Medicare-and-included-in-CPT-code-set.pdf).

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- CPT Code 99281 emergency department visits include "[a] problem focused history; [a] problem focused examination; and [s]traightforward medical decision making. . . . Usually, the presenting problem(s) are self limited or minor." *Id.* at 22.

- CPT Code 99282 emergency department visits include "[a]n expanded problem focused history; [a]n expanded problem focused examination; and [m]edical decisionmaking of low complexity. . . . Usually, the presenting problem(s) are of low to moderate severity." *Id.*

- CPT Code 99283 emergency department visits include "[a]n expanded problem focused history; [a]n expanded problem focused examination; and [m]edical decision making of moderate complexity. . . . Usually, the presenting problem(s) are of moderate severity." *Id.* at 23.

- CPT Code 99284 emergency department visits include "[a] detailed history; [a] detailed examination; and [m]edical decision making of moderate complexity. . . . Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function." *Id.*

- CPT Code 99285 emergency department visits include "[a] comprehensive history; [a] comprehensive examination; and [m]edical decision making of high complexity. . . . **Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function**." *Id.* (emphasis added).

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CPT code 99281 indicates the least severe level of ER service, while CPT code 99285 represents the most severe level. CPT code 99285 is reserved for emergencies that pose an immediate significant threat to life or physiological function. CPT codes 99291 and 99292 represent "critical care," accounting for the very small fraction of ER visits each year[26] that require a physician's undivided attention to a single patient to mitigate one or more vital organ system failures.[27]

53. A central administrative group at TeamHealth's corporate offices in Alcoa, Tennessee handles the "coding." They take the medical records generated by TeamHealth's healthcare contractors, and they decide what CPT code to bill for the work performed. After reviewing the medical record generated by the healthcare contractor, a TeamHealth "coder" assigns one of the CPT codes. TeamHealth then submits the codes to insurance companies, including Celtic, as an insurance claim.

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54. TeamHealth's coders are administrative employees hired and trained by TeamHealth; they are not ER doctors and most have no medical training.

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- Critical Care CPT Code 99291 denotes the first 30-74 minutes of care for "the critically ill or critically injured patient," *id.*, who suffers from "[an] acute[] impair[ment of] one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition," Medicare Claims Processing Manual at Ch. 12, § 30.6.12(A) (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf). Critical care demands "high complexity decision making." *Id.* A provider must report as "[t]he duration of critical care . . . the time the physician spent evaluating, providing care [for] and managing the critically ill or injured patient[]" in the patient's immediate vicinity. *Id.* at § 30.6.12(C). For any period of critical care, the physician "must devote his or her full attention to the patient." *Id.*

- Critical Care CPT Code 99292 marks each subsequent 30 minutes of critical care of the same kind as 99291. Synovec et al. at 22–23.

[26] https://www.cdc.gov/nchs/fastats/emergency-department.htm (ER statistics).

[27] Medicare Claims Processing Manual at Ch. 12, § 30.6.12(A).



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55. TeamHealth's front-line doctors and physician's assistants do not see the code selected by TeamHealth's coders, nor do the front-line workers see the insurance claim or billed amount submitted by TeamHealth. They have no idea how TeamHealth bills their services—or for how much—even though the bills often are submitted in their names. They are not involved in assigning codes to the services they provide, and they are not consulted regarding what code should be billed.[28]

56. In a recent deposition, Dr. Hamilton Lempert, TeamHealth's head of coding policy, explained that the company does not trust its front-line healthcare contractors to assign billing codes.[29] Dr. Lempert confirmed that, during the coding process, coders do not discuss the medical records or coding with the front-line healthcare contractor.[30] Instead, the coder relies on his or her own judgment and TeamHealth's policies in converting medical records into billing codes. The doctor or physician's assistant who provided the service has no input on what billing code is assigned to the service.

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57. One of TeamHealth's healthcare contractors described the situation in a statement to the press:

> "**As an emergency medicine physician, I have absolutely no idea to whom or how much is billed in my name.** I have no idea what is collected in my name. This is not what I signed up for and this isn't what most other ER docs signed up for. I went into medicine to lessen suffering, but as I understand more clearly my role as an employee of TeamHealth, I realize that I'm unintentionally worsening some patients' suffering."[31]

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[28] Lempert Dep., 42:8-11.

[29] Lempert Dep., 37:4-38:2.

[30] Lempert Dep., 42:8-11.

[31] Arnsdorf, *supra* note 17 (emphasis added).



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58. When TeamHealth bills insurance companies, TeamHealth almost never includes medical records showing what service was actually provided. Therefore, an insurance company cannot compare the codes on the health insurance claims to documentation regarding the service provided. TeamHealth makes representations that the codes on the health insurance claims accurately describe the service provided, without giving the insurer medical records that could be used to verify those representations.

59. Because of the large volume of claims submitted every day and the laws prohibiting health insurance fraud, the insurance industry reasonably relies on TeamHealth's representations.

60. In accordance with its usual practice, TeamHealth has submitted hundreds of thousands of health insurance claims to Celtic without including the underlying medical records. Celtic paid TeamHealth's claims for ER services in reliance on TeamHealth's representations on the health insurance claims.

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61. A review of recently acquired medical records from TeamHealth shows that TeamHealth has routinely "upcoded" health insurance claims that it has submitted to Celtic's Affordable Care Act insurance plans. Celtic discovered TeamHealth's upcoding on Celtic ACA claims in the course of defending against litigation that TeamHealth initiated against Celtic in Arkansas. In that case, TeamHealth was demanding higher payments from Celtic for its ER services, but TeamHealth refused to provide the medical records showing what services its healthcare contractors actually performed. In June 2020, the Arkansas court ordered TeamHealth to produce the medical records to Celtic.

62. In July 2020, Celtic reviewed a sample of the medical records produced by TeamHealth for insurance claims that TeamHealth billed at the highest severity level. A spreadsheet detailing the results of Celtic's review is attached as EXHIBIT 1. Celtic's review



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exposed a systematic pattern of upcoding by TeamHealth. TeamHealth systematically assigned the highest ER code, 99285—a code reserved for conditions that immediately threaten life or physiological function—to claims where the patient reported complaints like headaches, flu-like symptoms, fever, aches, bug bites, or anxiety. TeamHealth billed 100% of those health insurance claims under a doctor's name.

63. Celtic's expert in that case concluded that a material portion of TeamHealth's health insurance claims were upcoded:

> "[M]y team randomly selected a probe sample of 30 of the medical bills at issue that [TeamHealth] coded with CPT code 99285 for review. [A] Certified Professional Coder, Certified Outpatient Coder and Certified Risk Adjustment Coder on my team, has now reviewed the remaining medical records provided by [TeamHealth] that allegedly support these 30 randomly selected medical bills. She had the following findings based on her review of documentation available to her to date:
>
> - **Documentation reviewed did not always support a face-to-face encounter with the physician when the ED [Emergency Department] team included a non-physician practitioner**;
> - One of the 30 medical records could not be evaluated due to a missing physician visit note;
> - **18 of the 29 medical records reviewed did not support the CPT code that appeared on the medical bill;**
> - **The 18 medical bills that were "upcoded" represent 62% of the medical bills reviewed containing CPT code 99285;**
> - 13 of the 18 "upcoded" medical bills should have been assigned CPT code 99284;
> - Five of the 18 "upcoded" medical bills should have been assigned CPT code 99283;
> - 11 of the 29 reviewed medical bills were correctly assigned CPT code 99285."
>
> See *Southeastern Emergency Physicians v. Arkansas Health & Wellness et al.*, Case No. 17-cv-00492-BSM (E.D. Arkansas), Dkt No. 204-2 (emphasis added).

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64. Celtic's expert concluded that many of the medical records did not support the billing code that TeamHealth submitted on its health insurance claims. For example:[32]

- On April 25, 2015, a doctor under contract with TeamHealth saw a patient who complained of "abdominal pain." **The notes reflect that the "patient has been re-examined and the patient has been informed of all results and diagnosis. The patient is ready for discharge." The patient was instructed to follow up "with PCP [primary care physician] if not improving and to return to ED for any acute worsening."** TeamHealth submitted a health insurance claim to Celtic for this work on claim # 149655068/400. TeamHealth billed this work as CPT Code 99285, the highest-severity ER code. TeamHealth listed the billed charge as $1,255.00, about 8 times what Medicare would pay for this work, and about 6.5 times what ACA insurance would pay for this work.

  Celtic's expert determined—upon review of the medical record associated with the claim—**that this claim should have been billed as CPT code 99284**. The difference between the amounts paid for a 99285 claim and a 99284 claim is material, and adds up to tens of millions of dollars across tens of thousands of claims.

- On December 21, 2016, a nurse under contract with TeamHealth saw a patient who **complained of a "headache that began this morning." The patient's husband "states she feels this way because she took too much xanax today." The nurse's notes reflect that the patient "states her headache is improved" and was discharged and "instructed to return immediately with any worsening symptoms, otherwise call and schedule appointment for follow up with PCP [primary care physician] as soon as possible."** TeamHealth submitted a health insurance claim to Celtic for this work on claim # 179526660/400. TeamHealth submitted this claim under a doctor's name, even though the medical records show that **no doctor saw the patient**.[33] TeamHealth billed this work as CPT Code 99285, the highest-severity ER code. TeamHealth listed the billed charge as $1,384.00, about 8 times what Medicare would pay for this work, and about 6.5 times what ACA insurance would pay for this work.

  Celtic's expert determined—upon review of the medical record associated with the claim—**that this claim should have been billed at most as CPT code 99284**. The difference between the amounts paid for a 99285 claim and a 99284

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[32] For privacy reasons, the medical records described herein are not attached as exhibits to this Complaint. For detail on all 30 records in the expert's review, see EXHIBIT 1.

[33] The fact that no doctor saw the patient associated with claim # 179526660/400 also is relevant to TeamHealth's second billing fraud: billing physician's assistants under a doctor's name. *See infra* Section III.B.



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claim is material, and adds up to tens of millions of dollars across tens of thousands of claims.

- On April 3, 2017, a nurse under contract with TeamHealth saw a patient who **complained of "lower abdominal and pelvic pain, described as cramping, that began 3 nights ago." The nurse's notes in the medical record reflect: "Today, feels mild dull ache but pain is gone." The nurse's notes reflect that the patient "wants to go home,"** and was instructed to "call and schedule appointment for follow up with PCP [primary care physician] as soon as possible." TeamHealth submitted a health insurance claim to Celtic for this work on claim # 185326043/400. TeamHealth submitted this claim under a doctor's name, even though the medical records show that **no doctor saw the patient**.[34] TeamHealth billed this work as CPT Code 99285, the highest-severity ER code. TeamHealth listed the billed charge as $1,384.00, about 8 times what Medicare would pay for this work, and about 6.5 times what ACA insurance would pay for this work.

  Celtic's expert determined—upon review of the medical record associated with the claim—**that this claim should have been billed as CPT code 99284**. The difference between the amounts paid for a 99285 claim and a 99284 claim is material, and adds up to tens of millions of dollars across tens of thousands of claims.

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- On July 13, 2017, a doctor under contract with TeamHealth saw a patient who **complained of "abdominal pain." The notes reflect that "pt [patient] was reassured" and was told to "return with increased pain or problems."** TeamHealth submitted a health insurance claim to Celtic for this work on claim # 191102925/400. TeamHealth billed this work as CPT code 99285, the highest-severity ER code. TeamHealth listed the billed charge as $1,384.00, about 8 times what Medicare would pay for this work, and about 6.5 times what ACA insurance would pay for this work.

  Celtic's expert determined—upon review of the medical record associated with the claim—**that this claim should have been billed as CPT code 99284**. The difference between the amounts paid for a 99285 claim and a 99284 claim is material, and adds up to tens of millions of dollars across tens of thousands of claims.

- On August 15, 2017, a doctor under contract with TeamHealth saw a patient who **complained of "a typical headache for her." The discharge notes reflect that the patient was sent "home to rest."** TeamHealth submitted a health insurance claim to Celtic for this work on claim # 193092470/400. TeamHealth billed this work as CPT code 99285, the highest-severity ER code. TeamHealth listed the billed charge as $1,602.00, about 10 times what

[34] *See infra* Section III.B.



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Medicare would pay for this work, and about 7.5 times what ACA insurance would pay for this work.

Celtic's expert determined—upon review of the medical record associated with the claim—**that this claim should have been billed as CPT code 99283**. The difference between the amounts paid for a 99285 claim and a 99283 claim is material, and adds up to tens of millions of dollars across tens of thousands of claims.

- On September 25, 2017, a doctor under contract with TeamHealth saw a patient who **complained of a "possible spider bite" "3 days ago."** The doctor instructed the patient to "f/u [follow up] with PCP [primary care physician] in 2 days and to return to ED if not improving or new or worrisome symptoms." TeamHealth submitted a health insurance claim to Celtic for this work on claim # 195542695/400. TeamHealth billed this work as CPT code 99285, the highest-severity ER code. TeamHealth listed the billed charge as $1,602.00, about 10 times what Medicare would pay for this work, and about 7.5 times what ACA insurance would pay for this work.

  Celtic's expert determined—upon review of the medical record associated with the claim—**that this claim should have been billed as CPT code 99283**. The difference between the amounts paid for a 99285 claim and a 99283 claim is material, and adds up to tens of millions of dollars across tens of thousands of claims.

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- On March 18, 2018, a doctor under contract with TeamHealth saw a patient who **complained of a "fever for 3 days." The patient "does state that her sister was recently diagnosed with the flu days ago." The notes reflect "Presenting problems: low," and that the patient "was given a prescription for Tamiflu, and nausea medication. Instructed patient to follow up with primary care physician in 1-2 days."** TeamHealth submitted a health insurance claim to Celtic for this work on claim # 208596757/400. TeamHealth billed this work as CPT code 99285, the highest-severity ER code. TeamHealth listed the billed charge as $1,682.00, about 10 times what Medicare would pay for this work, and about 7.5 times what ACA insurance would pay for this work.

  Celtic's expert determined—upon review of the medical record associated with the claim—**that this claim should have been billed as CPT code 99283**. The difference between the amounts paid for a 99285 claim and a 99283 claim is material, and adds up to tens of millions of dollars across tens of thousands of claims.

65. This evidence of upcoding is further supported by a review of more than 10,000 of TeamHealth's medical records by one of Celtic's affiliates this year. That review determined that nearly two-thirds of the TeamHealth's health insurance claims that were billed as CPT code 99285



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or 99284 had been "upcoded" by TeamHealth and should have been billed as CPT code 99283. A spreadsheet with claim-level information regarding the claims identified in this review as upcoded is attached as EXHIBIT 2.

66. Health insurance claims data from the past year illustrate the abnormal distribution of CPT codes billed by TeamHealth to Celtic for Celtic's Affordable Care Act members. According to an analysis of millions of health insurance claims, the *expected* CPT code distribution of ER claims (i.e., the proportion of claims billed at each of the five code levels) is materially different from the *actual* CPT codes billed by TeamHealth to Celtic for Affordable Care Act members. The difference is stark between TeamHealth's coding behavior and the expected coding behavior based on millions of claims:

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| **CPT Code:** | **Expected CPT code frequency based on millions of ER claims:** | **Frequency of CPT code billed by TeamHealth to Celtic for Affordable Care Act insurance members:** |
|---|---|---|
| **99285 (Level 5)** | 27.26% | **48%** |
| **99284 (Level 4)** | 31.31% | **34%** |
| **99283** | 37.02% | **17%** |
| **99282** | 3.86% | **1%** |
| **99281** | .55% | **0%** |

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67. Health insurance claims data also show that TeamHealth bills Celtic for Celtic's Affordable Care Act members in a manner that is materially more aggressive than for Medicaid members. Because the needs of the population with Medicaid coverage are in general similar to the needs of the population with Affordable Care Act insurance, the disparity between TeamHealth's coding behavior for these two types of insurance shows that TeamHealth is upcoding Affordable Care Act claims:



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| CPT Code: | Claims that TeamHealth billed as Level 5 on Medicaid members: | Claims that TeamHealth billed as Level 5 to Celtic on Affordable Care Act members: |
|---|---|---|
| **99285 (Level 5)** | Less than 30% | **48%** |

68. TeamHealth's inflated coding seeks to profit from the fact that many Americans use emergency rooms to address all sorts of concerns that do not present emergent situations. Based on a 2017 survey, there were approximately 43 ER visits per 100 persons in the U.S. each year.[35] Of those visits, approximately 28 percent were "semiurgent" or "nonurgent."[36] That reality gives TeamHealth ample opportunity to upcode and get paid as if most of its patients have life-threatening emergencies when in fact they often need more routine medical services.

69. Attached as EXHIBIT 3 is a detailed list of 191,556 health insurance claims that TeamHealth submitted to Celtic for a service provided to a Celtic Affordable Care Act member. In every one of these 191,556 health insurance claims, TeamHealth made a representation to Celtic that the service merited a CPT code of 99285 or 99284—the two highest ER CPT codes. As described in this Complaint, TeamHealth's representations to Celtic were false and fraudulent on a material number of the 191,556 health insurance claims listed in EXHIBIT 3. EXHIBIT 3 provides information about the affiliate under which TeamHealth billed the claim, the claim number, the age of the Celtic ACA member, the date of service, the date that Celtic received the health insurance claim, the date that Celtic paid the claim, and the CPT code that TeamHealth billed. EXHIBIT 3 shows that of the 191,556 health insurance claims that TeamHealth billed to Celtic at the two highest CPT codes, TeamHealth billed 114,630 claims at a Level 5 (CPT code

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[35] Centers for Disease Control & Prevention, *National Hospital Ambulatory Medical Care Survey: 2017 Emergency Department Summary Tables* (Dec. 2017), https://www.cdc.gov/nchs/data/nhamcs/web_tables/2017_ed_web_tables-508.pdf.

[36] *Id.*



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99285) and 76,926 claims at a Level 4 (CPT code 99284). TeamHealth submitted additional claims to Celtic under affiliate names not identified in EXHIBIT 3. A partial list of suspected TeamHealth affiliates involved in the fraudulent scheme is attached as EXHIBIT 4 (identifying 133 suspected TeamHealth affiliates, many of which TeamHealth uses to bill insurance companies, including Celtic).

70. TeamHealth has also billed Celtic for ER "critical care" CPT codes that are not warranted, and has billed these codes at an unjustifiably high rate. Critical care CPT codes are different from the 99281 through 99285 CPT codes discussed above. Critical care codes are reserved for rare situations where there is a high probability of sudden, clinically significant, or life-threatening deterioration in the patient's condition, which requires the highest level of physician preparedness to intervene urgently.

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71. TeamHealth's upcoding practices have been the subject of other lawsuits. The common thread among the cases is that TeamHealth, via its various subsidiaries and affiliates, improperly inflates the health insurance claims that it submits to insurance companies, the government, and patients via "upcoding." For example:

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> In *United States ex rel. Hernandez v. Team Health, Inc.*, No. 2:16-CV-00432-JRG, 2020 WL 731446 (E.D. Tex. Feb. 13, 2020), the complaint alleged classic "upcoding" billing schemes. The judge in that case denied TeamHealth's motion to dismiss. The judge wrote, quoting the plaintiffs' complaint:
>
> > 8. The second Scheme is the "Critical Care Scheme." This Scheme is a classic upcoding scheme. Under the Critical Care Scheme, TeamHealth bills CMS for "critical care"—the highest level of emergency treatment reserved for life-threatening situations—when in fact critical care services were not rendered and/or were not medically necessary, thereby submitting false claims through fraudulent billing. For example, in an April 2014 email from TeamHealth West Associate Medical Director Elisa Dannemiller, Relator Dr. Hernandez was told, "Just a reminder to keep up the critical care



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> billing! Abnormal vital signs, ICU admits, blood transfusions, trauma activations, and IV ggts all warrant critical care. We are still missing some obvious opportunities . . . ." However, these situations Dannemiller lists do not necessarily, and likely do not, require critical care in every instance because they do not necessarily meet the CMS definition for "critical care." Yet Dannemiller told healthcare providers that all of these situations warrant critical care every time. Dannemiller also explained in an October 2, 2013 PowerPoint presentation, "[y]ou can bill for critical care and send the patient home!" And in an October 26, 2014 email, Dannemiller imposed critical care billing quotas at 6-12%. . . .
>
> 10. TeamHealth employs this Scheme through its billing policies and practices to bill federal and state governments for millions of dollars for the services concerned. Through the Critical Care Scheme, TeamHealth has fraudulently obtained multiple millions of dollars each year since at least 2011 (when Relators began working for TeamHealth). Based on information and belief, TeamHealth began the Scheme much earlier than 2011 and continues to employ the Critical Care Scheme today.
>
> 11. TeamHealth is able to conceal these fraudulent claims because a critical care claim is a "pass through" claim for billing purposes, meaning there is no front-end auditing of these charges. For example, the April 2, 2014 TeamHealth Meeting Minutes reveal the following findings from a meeting regarding charting and billing: "Critical care billing has tapered to 3% compliance in February. There is significant variability in billing for those services and continued efforts are occurring to reach the desired 5–8%. Anything that can be done to enhance charting to collect more through billing is greatly appreciated and members noted that this type of charge is a pass through for billing, noting there is no auditing of these charges." *Hernandez*, 2020 WL 731446, at *3–*4.

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72. Similarly, in *Emergency Care Services of Pennsylvania et al. v. UnitedHealth Group et al.*, Case No. 5:20-cv-5094 (E.D. Pa.), UnitedHealth Group filed a counterclaim against members of the TeamHealth enterprise. ECF No. 37 of E.D. Pa. Case No. 5:20-cv-5094 (filed on Nov. 20, 2020). UnitedHealth explained that TeamHealth engaged in classic upcoding on health insurance claims that TeamHealth submitted to United. *See id.* at ¶¶ 27 & 28:

> Upon review of the claim submissions that Plaintiffs/Counter-Defendants submitted to United for procedures and services that they billed using CPT codes 99283, 99284, and 99285, United discovered that the medical records and other documentation did not support the use of the reported codes in over 64% of these claims.



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> In particular, for CPT code 99285, United found that the CPT code was unsupported in approximately 82% of the claims submitted to United by Plaintiff/Counter-Defendant Emergency Care Services of PA, P.C., and in approximately 79% of the claims submitted to United by Plaintiff/Counter-Defendant Emergency Physician Associates of PA, P.C. In other words, for each of these claims, the use of CPT code 99285 was unsupported by the underlying medical records and documentation maintained by the Plaintiffs/Counter-Defendants. As such, the reporting of CPT code 99285 improperly resulted in higher remittance payments than those to which Plaintiff/Counter-Defendants were actually entitled.

73. As a result of TeamHealth's upcoding, Celtic has paid TeamHealth more than was warranted on tens of thousands of claims. Had TeamHealth assigned billing codes that accurately reflected the services provided, Celtic would have paid substantially less.

74. TeamHealth is able to conceal its upcoded health insurance claims because (a) the healthcare contractor who provided the service does not see the health insurance claims that TeamHealth submits to Celtic, (b) the patient who received the service does not see the health insurance claim that TeamHealth submits to Celtic, and (c) TeamHealth typically does not provide—and, indeed, has refused to provide when asked—medical records to Celtic. TeamHealth abuses this information asymmetry, and the large volume of claims it submits every day, to perpetrate fraud.

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75. When patients find out that TeamHealth billed a "high severity" billing code for what the patient knows was a relatively minor service—like treatment for an ear infection—patients have complained publicly. For example, in August 2018, a mother found out that TeamHealth billed the Level 4 code (99284) for treating her child's ear infection. The mother submitted the following complaint to the Better Business Bureau:

> TeamHealth send me a bill for services rendered by Dr G****** in April 2018. My kid visited the ER on a Saturday, **due to a ear infection with low fever**. After a quick examination, it was determined it was a ear infection and the doctor prescribed antibiotics. Right after the visit I received the bill from the hospital and we paid it. About a month later we receive a bill from TeamHealth for $1083 for "Emergency dept visit - G****** MD, **** *." **After some digging I found out**



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> **they had coded the visit as 99284 which the second to highest complexity procedure code for the ER**, that uses a range from 99281–99285. After hours on the phone they sent the bill back for code review, two months later they say the code is correct and they "decided" $1083 was the correct charge based on the procedure. By looking at the BBB complaint history, there seem to be some kind of systematic issue with the coding and rates this company is using. While on the phone, after my call was escalated to the code review department, I was "explained" each company has their own code descriptions and may use different codes for the same procedures, which doesn't sound right for a regulated industry. I did some research and I got the impression that the bill I received is between 2 and 3 times the usual amount for the same billing code (99284), and also that the appropriate code for a ear infection (otitis) would be 99282, which is significantly less expensive than 99284.[37]

76. Every time TeamHealth submitted a health insurance claim to Celtic, TeamHealth certified as follows: "the information on this form is true, accurate and complete," and "the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction." On a material number of health insurance claims that TeamHealth submitted to Celtic, these certifications were false.

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77. Every time that TeamHealth submitted a health insurance claim to Celtic, TeamHealth also certified that it was in possession of an assignment of benefits form, signed by the patient-member who received the service, assigning the member's benefits from their Affordable Care Act health insurance to TeamHealth. On a material number of health insurance claims that TeamHealth submitted to Celtic, this certification was false because TeamHealth was not in fact in possession of a signed assignment of benefits form. In fact, the member had no idea that a TeamHealth-affiliated health care contractor had performed the services.

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[37] Better Business Bureau Medical Billing Complaints (Aug. 2018), https://www.bbb.org/us/oh/akron/profile/medical-billing/akron-billing-center-0272-20000634/complaints (emphasis added). A TeamHealth employee responded to this complaint, writing on the Better Business Bureau website: "services rendered in the ER are considered high priority cases and charges are extremely higher than other providers." *Id.*



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78. None of the additional revenue that TeamHealth wrongfully gained through upcoding went to the front-line doctors and physician's assistants who treated the patients, because they are paid by TeamHealth by the hour, purportedly as "independent contractors." The additional revenue generated through TeamHealth's fraud went directly to TeamHealth's bottom line.[38] In fact, TeamHealth's chief financial officer has acknowledged that what TeamHealth charges does not affect how much TeamHealth pays its healthcare contractors who perform the relevant services.[39]

### B. Billing for Services Provided by a Physician's Assistant as if a Doctor Provided the Service.

79. TeamHealth systematically bills for services provided by physician's assistants as if a doctor provided the service. In the healthcare industry, services provided by a physician's assistant are paid at lower rates than services provided by a doctor. For example, Celtic's billing manual states that Celtic pays for services provided by a physician's assistant "at 85% of what a physician is paid" under the appropriate fee schedule. CMS has the same billing standards. By misrepresenting to Celtic that a doctor provided the service—rather than a physician's assistant—TeamHealth has submitted thousands of overbilled and fraudulent insurance claims to Celtic. On thousands of health insurance claims that TeamHealth submitted to Celtic, TeamHealth concealed the fact that a physician's assistant provided the service, and instead misrepresented to Celtic that a doctor did. This is another form of "upcoding."

80. Physician's assistants are qualified to provide certain ER services. TeamHealth contracts with physician's assistants, and pays them on a physician's assistant pay scale. But

[38] Arnsdorf, *supra* note 17.

[39] Arnsdorf, *supra* note 17.

TeamHealth systematically bills their work under a doctor's name and at a doctor's rate. TeamHealth keeps the extra money obtained through this fraud; the physician's assistants do not receive the benefit of TeamHealth's upcoding.

81. Data shows that TeamHealth submitted health insurance claims to Celtic under a doctor's name nearly 100% of the time in all states in which TeamHealth operates. By contrast, an analysis of more than 11 million claims submitted to Medicare across various states and various years shows that ER providers typically submit insurance claims under a doctor's name only about 82% of the time, and under a physician's assistant's name about 18% of the time.

82. TeamHealth's practice of billing services provided by a physician's assistant under a doctor's name has been the subject of other litigation. For example:

> In *United States ex rel. Hernandez v. Team Health, Inc.*, No. 2:16-CV-00432-JRG, 2020 WL 731446 (E.D. Tex. Feb. 13, 2020), the complaint alleged that TeamHealth bills services by physician's assistants under a doctor's name. The judge in that case denied TeamHealth's motion to dismiss. *Id.* at *11. The judge wrote, quoting the plaintiffs' complaint:
>
> > "Under the Mid-Level Scheme, TeamHealth overbills for services provided by "mid-level" practitioners. The term "mid-level" refers to non-physician healthcare providers, such as Physician Assistants ("PAs") and Nurse Practitioners ("NPs"). Under Centers for Medicare and Medicaid Services ("CMS") rules, a mid-level's services are reimbursed at 85% of the standard physician rate, while services rendered by a physician are reimbursed at 100% of the standard physician rate. These rates and percentages are set by CMS, and the Plaintiff States have largely, if not entirely, adopted these same rates and percentages for reimbursement." *Id.* at *2.

83. Patients sometimes complain publicly when they find out that TeamHealth billed for a doctor's service, when the patient knows that no doctor saw him or her. For example, in February 2020 a patient submitted the following complaint to the Better Business Bureau:



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> Akron Billing Department (teamhealth.com) sent me a bill for physician service from DR. Scott M******* at Brandywine hospital on 9/13. **I went to ER that day for minor burns, and all what happened was two nurses provided me with antibiotic cream. Dr. Scott M******* never seen me and never entered my room or provided me any kind of service.** The bill I received was for $1454 for basically a Physician service that I didn't get, the bill also has a charge for surgery/removal of burn tissue which never happened since they never removed any burn tissue, and/or dressing change which never happened as my wife was with me and she helped me dressing, all service I received only applying an anti-biotic cream for $15 and tetanus shot that I paid the hospital for.[40]

84. By upcoding health insurance claims from a physician's assistant's name to a doctor's name, TeamHealth—without the doctor's or physician's assistant's knowledge—extracts a greater payment from an insurance company (or patient) than is warranted. In reality, physician's assistants routinely provide quality care to patients in the ER—but TeamHealth submits health insurance claims as if that fact were not true.

### C. Billing Charges that Are Eight, Nine, or Ten Times the Amount Allowed by Medicare.

85. Because TeamHealth acts as a gatekeeper between its healthcare contractors and insurance companies, TeamHealth decides whether its healthcare contractors in a particular hospital will be in-network with a particular insurance plan, or out-of-network. To maximize profits, TeamHealth often pursues an "out-of-network strategy," opting not to contract with insurance companies and instead billing extremely high "billed charges," which TeamHealth unilaterally sets.

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[40] Better Business Bureau Medical Billing Complaints (Feb. 2020), https://www.bbb.org/us/oh/akron/profile/medical-billing/akron-billing-center-0272-20000634/complaints (emphasis added). A TeamHealth employee responded to this complaint, writing on the Better Business Bureau website: "As you are aware we bill for [physician] provider services which also include physicians assistants and nurse practitioners. Carolyn B**** PA-C, a physicians assistant, has signed off on your medical records and is the physician assistant working with Dr. M*******. You may request a copy of your medical records from the hospital for your review of PA-C's history, exam and diagnosis." *Id.*



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86. By submitting thousands of claims to Celtic listing charges that are often eight, nine, or ten times the amount allowed by Medicare, TeamHealth tries to extract more than its fair share of dollars from the healthcare system, and it has even sued patients (thousands of times) and insurance companies to collect on these extremely high charges. TeamHealth has frequently balance billed patients for the difference between what the insurer pays for out-of-network services and TeamHealth's extremely high billed charges. When the patient is unable to pay that amount, TeamHealth often threatens to sue patients (or insurance companies) to collect their billed charges, and it has followed through on its threats thousands of times.

87. TeamHealth's inflated "billed charges" have been the subject of other litigation. For example:

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In *Fraser v. Team Health Holdings, Inc.*, Case No. 20-4600 (N.D. Cal. filed July 10, 2020), the complaint alleged that TeamHealth routinely tries to collect inflated "billed charges" from patients:

> "TeamHealth is a private equity-funded corporation that contracts with hospitals to take over their emergency, critical care, radiology, and anesthesiology departments, supplying them with doctors and other medical professionals as well as running their administrative functions.
>
> In 2016, TeamHealth boasted that it controlled 17% of the emergency medicine market in the United States. Currently, it operates 3,300 acute and post-acute facilities in 47 states. . . .
>
> **The TeamHealth Fraudulent Billing Enterprise maximizes its profits by sending fraudulent bills to patients for the care they receive from TeamHealth physicians. TeamHealth has inflated the rates it charges patient-consumers far above those that it knows it is legally entitled to collect from those patients**."

Class Action Compl. ¶¶ 1–2, 6, *Fraser v. Team Health Holdings, Inc.*, Case No. 20-4600 (N.D. Cal. July 10, 2020).

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88. Ultimately, TeamHealth's billing schemes harm patients. Inflated health insurance claims improperly increase cost-sharing obligations for patients, and ultimately drive up the cost of health care. For patients on Affordable Care Act insurance like that offered by Celtic, TeamHealth's billing schemes not only increase costs for patients but also put upward pressure on premiums that may cause the federal and state governments to spend more on cost-sharing subsidies and other taxpayer-funded support.

89. Neither patients, nor CMS, nor state healthcare regulators are in a position to discover or address TeamHealth's upcoding because they lack access to (a) the medical records, which show what services actually were rendered, or (b) the health insurance claims submitted to insurers, which show which billing code TeamHealth assigned to the services. Only TeamHealth has access to both of those, because TeamHealth does not typically provide—and often resists providing—medical records to insurance companies.

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## CLAIMS FOR RELIEF

### I. COUNT I: RACKETEER INFLUENCED AND CORRUPT ORGANIZATIONS ACT ("RICO") — 18 U.S.C. § 1962(c)

90. Celtic incorporates by reference the allegations in each of the preceding paragraphs as if fully set forth herein.

91. RICO makes it "unlawful for any person employed by or associated with any enterprise engaged in, or the activities of which affect, interstate or foreign commerce, to conduct or participate, directly or indirectly, in the conduct of such enterprise's affairs through a pattern of racketeering activity." 18 U.S.C. § 1962(c).

92. RICO also provides: "Any person injured in his business or property by reason of a violation of [18 U.S.C. § 1962] may sue therefor in any appropriate United States district court



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and shall recover threefold the damages he sustains and the cost of the suit, including a reasonable attorney's fee[.]"

93. Celtic is a "person" within the meaning of 18 U.S.C. §§ 1961(3) & 1964(c).

94. Defendants are each a "person" within the meaning of 18 U.S.C. § 1961(3).

**A. The TeamHealth Upcoding Enterprise**

95. A RICO "enterprise" "includes any individual, partnership, corporation, association, or other legal entity, and any union or group of individuals associated in fact although not a legal entity." 18 U.S.C. § 1961(4).

96. For purposes of this Complaint, the relevant enterprise, herein referred to as the "TeamHealth Upcoding Enterprise," or "the Enterprise," is an association in fact, consisting of: (a) TeamHealth; (b) TeamHealth's direct regional subsidiaries; (c) the individual corporations and other legal entities that employ and/or contract with the healthcare contractors whose services TeamHealth sells, and which TeamHealth either indirectly owns through its regional subsidiaries or controls *de facto*.

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97. Both Defendants have an existence separate and distinct from the Enterprise, in addition to directly participating in and acting as a part of the Enterprise.

98. Although the various components of the Enterprise play different roles, they all serve a common purpose: allowing TeamHealth to submit fraudulently upcoded health insurance claims to insurers, and to keep the difference between the amount received as a result of the upcoded claim, and the amount that would have been received had the claim been properly coded.

99. The front-line healthcare workers employed as independent contractors by the Enterprise's corporate subsidiaries and/or *de facto* controlled affiliates provide medical services to patients in emergency rooms.



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100. TeamHealth's numerous subsidiaries and affiliates—over 100 separate entities, including those identified in EXHIBIT 4—have a mixture of corporate ownership structures. Some of TeamHealth's affiliates are wholly owned by TeamHealth; others are partially owned by TeamHealth; and some are wholly owned by others. For example, ACS Emergency Services is a TeamHealth affiliate, and is listed as item 3 on EXHIBIT 4. ACS Emergency Services is wholly owned by one of the co-founders of TeamHealth.

101. Without these corporations and the healthcare contractors who provide services, the Enterprise would have nothing to upcode.

102. The Enterprise's regional subsidiaries oversee the entities employing or contracting with healthcare contractors, and they negotiate contracts with hospitals as conduits of the Enterprise. Without the regional subsidiaries and the hospitals through which Enterprise's subsidiaries deploy its healthcare contractors, the Enterprise's healthcare contractors would have no patients to service, and TeamHealth's ability to efficiently coordinate and direct the activities of the corporations employing the healthcare contractors would be diminished.

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103. TeamHealth coordinates the entire Enterprise; performs the upcoding; employs the staff that receives medical records from TeamHealth's healthcare contractors; and applies CPT codes to those records in accordance with policies dictated by TeamHealth.

104. The organization of the Enterprise, and specifically its use of subsidiaries and purported independent contractors rather than direct employment of healthcare contractors, facilitates the Enterprise's fraudulent upcoding scheme in two ways.

105. *First*, if TeamHealth directly employed all of the healthcare contractors controlled by it, or if it directly owned all the corporate practice groups that provide services on its behalf, TeamHealth would violate various state laws prohibiting the corporate practice of medicine. The



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Enterprise's complex legal structure is therefore essential to its functioning and to its ability to control and profit from healthcare providers who appear to patients and the public to be independent.

106. *Second*, by operating through subsidiaries and other entities that have names such as "Southeastern Emergency Physicians," TeamHealth tries to create the impression that patients have received services from a local doctors' group. TeamHealth almost never bills patients or insurance companies under its own name. This creates the illusion that its healthcare contractors are providing care that is locally owned and directed. This illusion disguises the truth and makes TeamHealth's fraud more difficult to detect, because it submits upcoded and inflated health insurance claims under the names of dozens of different corporate entities, with no indication that they are affiliated with TeamHealth. This illusion also helps protect TeamHealth politically and to insulate its activities, including by avoiding public scrutiny for the thousands of lawsuits it has filed under various corporate names against individuals and insurance companies.

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107. As the topmost corporate entity of what it calls the "TeamHealth system," TeamHealth conducts and directs the TeamHealth Upcoding Enterprise and sets policies that govern the functioning of all components of the Enterprise. TeamHealth is responsible for the actual upcoding, which occurs after its healthcare contractors submit medical records that document the actual services provided to the patient. TeamHealth uses those medical records and improperly exaggerates the services they reflect, consistent with TeamHealth's procedures, in order to submit a massive number of "upcoded" health insurance claims to insurance companies.

**B. TeamHealth's Pattern of Racketeering Activity**

108. RICO prohibits the conduct of an enterprise "through a pattern of racketeering activity." 18 U.S.C. § 1962(c). Racketeering acts are defined at 18 U.S.C. § 1961(1), and include mail fraud in violation of 18 U.S.C. § 1341 and wire fraud in violation of 18 U.S.C. § 1343.



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109. TeamHealth, through the TeamHealth Upcoding Enterprise, has committed tens of thousands of acts of mail fraud and wire fraud. Specifically, Team Health has conducted a scheme to defraud Celtic and insurers like Celtic, with specific intent to obtain money from those insurers by materially false and fraudulent representations, and to use the mails and interstate wires in furtherance of the scheme.

110. Central to TeamHealth's scheme to defraud is the systematic upcoding of medical services provided to insured patients by healthcare contractors that are under TeamHealth's control. TeamHealth's upcoding scheme misrepresents the nature of the services provided to Celtic's insureds, for the purpose of recovering more money from Celtic and from patients (via cost-sharing and/or surprise billing). Because insurers, including Celtic, do not have access to the underlying medical records that form the basis of TeamHealth's health insurance claims, and because of the massive volume of health insurance claims, insurers rely on TeamHealth's representations regarding the nature of the services provided.

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111. TeamHealth's scheme has been carried out with the specific intent to defraud Celtic and other insurers. The statistical evidence detailed above, as well as evidence that will be developed in discovery and presented at trial, indicates that TeamHealth has submitted a proportion of health insurance claims to Celtic under the highest CPT code for services by its healthcare contractors—and a proportion of its claims for services by doctors as opposed to physician's assistants—that is so large that many of the claims are false. Instances of upcoding in TeamHealth's health insurance claims are not mere isolated incidents, but instead are part of a pattern and practice of upcoding intended to increase TeamHealth's revenue and profits. The fact that TeamHealth's coding is conducted at a centralized location, under the oversight of



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TeamHealth management, further demonstrates that TeamHealth's tens of thousands of upcoded health insurance claims are not a matter of mere coincidence.

112. TeamHealth has used the mails and interstate wires in furtherance of its upcoding scheme to defraud Celtic in a number of ways, including:

a. Mail and wire receipt of medical records from TeamHealth-affiliated hospitals located throughout the country at TeamHealth's coding operations facility in Tennessee;

b. Mail and wire transmission of fraudulently upcoded health insurance claims from Tennessee to insurers, including Celtic, in numerous states throughout the country;

c. Mail and wire transmission of marketing materials to hospitals in order to sell TeamHealth's staffing services and expand the scope of the Enterprise;

d. Mail and wire receipt of money from insurers in various states, including Celtic, representing the unlawful proceeds of TeamHealth's fraudulent upcoding scheme;

e. Mail and wire communications between TeamHealth and its regional subsidiaries and provider groups in various states.

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113. TeamHealth's repeated acts of racketeering activity form a "pattern" under RICO because they occurred within ten years of each other, were continuous, and are related.

114. Through its many mailings and wire communications in furtherance of its scheme to defraud, TeamHealth has committed tens of thousands of acts of racketeering activity. These acts are part of a common scheme and have the same purpose: to extract greater payments from insurance companies than TeamHealth is entitled to. TeamHealth has adopted policies



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encouraging upcoding, and has a regular staff dedicated to coding that is trained to adhere to TeamHealth's practice of upcoding on a systematic basis. Upcoding is part of TeamHealth's regular way of doing business, and there is every reason to believe that, absent judicial intervention, TeamHealth will continue its upcoding scheme for as long as the scheme remains profitable.

**C. Injury to Celtic**

115. TeamHealth's upcoding scheme has directly caused injury to Celtic's business and property. Celtic suffers injury each time it pays a health insurance claim in reliance on TeamHealth's coding, where the CPT code on that claim does not accurately represent the service actually provided, or where the claim represents that the service was provided by a medical doctor when the service was actually provided by a physician's assistant. Celtic's damages consist of the difference between the amount that Celtic paid TeamHealth on each upcoded health insurance claim, and the amount that Celtic would have paid if the underlying medical services had been properly coded.

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116. By virtue of these violations of 18 U.S.C. § 1962(c), and pursuant to 18 U.S.C. § 1964(c), TeamHealth is liable to Celtic for three times the damage that Celtic has sustained, plus the cost of bringing this suit, including reasonable attorneys' fees.

117. Celtic also seeks injunctive relief requiring TeamHealth to alter its current policies incentivizing upcoding, retrain its coding staff to properly code medical records rather than systematically upcode medical records, and submit to a regular, at least yearly, audit of its coding practices by an independent monitor, with all costs of such audit to be paid by TeamHealth. Absent such an injunction, TeamHealth's upcoding is likely to continue, as it is a profitable, though unlawful, business strategy.



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## II. COUNT II: CONSPIRACY TO VIOLATE RICO — 18 U.S.C. § 1962(d)

118. Celtic incorporates by reference the allegations in each of the preceding paragraphs as if fully set forth herein.

119. The two Defendants, collectively referred to as TeamHealth, agreed with each other to pursue the schemes described above, namely, "classic" upcoding and falsely billing services provided by physician's assistants as though they were performed by a doctor, with the ultimate objective of realizing increased revenue and profits. Although Celtic only learned of this conspiracy within the last year, it began at least seven years ago, when Celtic started offering Affordable Care Act health insurance, and continues today.

120. Both Defendants took overt acts in furtherance of the conspiracy, namely, promulgating policies that required TeamHealth employee responsible for coding insurance claims to upcode those claims.

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121. Both Defendants knew that their policies would lead to a pattern and practice of submitting false and inflated claims to Celtic and other insurers, for the purpose of obtaining money from those insurers by materially false and fraudulent representations, and to the use of the mails and interstate wires in furtherance of the scheme.

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122. TeamHealth's upcoding scheme has directly caused injury to Celtic. Celtic suffers injury each time it pays a health insurance claim in reliance on TeamHealth's coding, where the CPT code on that claim does not accurately represent the service actually provided, or where the claim represents that the service was provided by a medical doctor when the service was actually provided by a physician's assistant. Celtic's damages consist of the difference between the amount that Celtic actually paid TeamHealth on each upcoded health insurance claim, and the amount that Celtic would have paid if the underlying medical services had been properly coded.



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123. By virtue of these violations of 18 U.S.C. § 1962(c), and pursuant to 18 U.S.C. § 1964(c), TeamHealth is liable to Celtic for three times the damage that Celtic has sustained, plus the cost of bringing this suit, including reasonable attorneys' fees.

124. Celtic also seeks injunctive relief requiring TeamHealth to alter its current policies incentivizing upcoding, retrain its coding staff to properly code medical records rather than systematically upcode medical records, and submit to a regular, at least yearly, audit of its coding practices by an independent monitor, with all costs of such audit to be paid by TeamHealth. Absent such an injunction, TeamHealth's upcoding is likely to continue, as it is a profitable, though unlawful, business strategy.

## III. COUNT III: FRAUD — Tennessee Common Law

125. Celtic incorporates by reference the allegations in each of the preceding paragraphs as if fully set forth herein.

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126. Each time TeamHealth submitted a health insurance claim for ER services to Celtic, TeamHealth made a representation of material fact: namely, that the CPT code appearing on the health insurance claim accurately represented the service provided to Celtic's insureds and who provided the service. Those representations were material to Celtic because they determined the amount that Celtic would pay to TeamHealth for each service.

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127. TeamHealth applied upcoding to a large proportion of the health insurance claims that it submitted to Celtic. When TeamHealth applied upcoding, the CPT code appearing on its health insurance claim did not, in fact, accurately represent the services provided to Celtic's insureds, or the doctor listed on the claim had not provided the service, which was instead provided by a physician's assistant. For example, each time that TeamHealth submitted to Celtic a health insurance claim with the CPT code 99285, it represented that the problem was high severity and



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posed an immediate significant threat to life or physiologic function. As set forth above, in tens of thousands of cases, those representations were false.

128. TeamHealth has made these false and fraudulent representations to Celtic on a regular and recurring basis since at least 2014, although Celtic did not discover the fraudulent nature of the representations to Celtic's Affordable Care Act insurance until 2020, when TeamHealth was ordered by a court on a motion to compel to produce certain medical records in litigation with Celtic. Because TeamHealth has exclusive control over the necessary facts, and because of the large volume of representations and Celtic's lack of access to all of the relevant medical records, it is not possible at this point to identify every specific instance of fraud by TeamHealth. Nonetheless, the health insurance claims described in EXHIBITS 1, 2 and 3 are more than adequate to put TeamHealth on notice of the nature of the allegations regarding its fraudulent claims.

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129. EXHIBIT 3 is a detailed list of roughly 200,000 health insurance claims that TeamHealth submitted to Celtic for Celtic's Affordable Care Act members in which TeamHealth made a representation to Celtic that the work performed merited a CPT code of 99285 or 99284—the two highest ER CPT codes.

130. TeamHealth knew that its representations were false, or at a minimum was reckless with regard to their truth, because TeamHealth has access to the underlying medical records for each patient, and is thus aware, in each instance of upcoding, that the medical services actually rendered do not match the representations on TeamHealth's health insurance claims, and/or that the services were not provided by a doctor as indicated on the claim form.

131. Celtic reasonably relied on TeamHealth's representations in making payment to TeamHealth for services rendered to Celtic's insureds. Because Celtic does not have access to



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patients' underlying medical records, and because of the volume of TeamHealth's health insurance claims, Celtic has reasonably relied on TeamHealth's representations in its health insurance claims in determining the amount of payment made to TeamHealth. Celtic discovered the substantial falsity of TeamHealth's representations to Celtic for Affordable Care Act claims through discovery in separate litigation.

132. Celtic was injured by TeamHealth's false representations in an amount to be determined at trial, specifically, through the difference between the amount that Celtic paid to TeamHealth based on the CPT codes and providers named in the health insurance claims that TeamHealth billed, and the amount that Celtic would have paid had TeamHealth submitted properly coded health insurance claims.

133. TeamHealth's misconduct was intentional, egregious, malicious, and reckless: TeamHealth consciously implemented a policy of systematic upcoding via its centralized coding staff in order to secure increased revenue and profits. As discussed above, TeamHealth's conduct was fraudulent. Therefore, TeamHealth is liable for punitive damages in an amount to be determined at trial.

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## IV. COUNT IV: NEGLIGENT MISREPRESENTATION — Tennessee Common Law

134. Celtic incorporates by reference the allegations in each of the preceding paragraphs as if fully set forth herein.

135. Celtic pleads this claim in the alternative to Count III.

136. Each time that TeamHealth submitted a health insurance claim to Celtic, TeamHealth made a representation of material fact: namely, that the CPT code appearing in the health insurance claim accurately represented the services provided by a TeamHealth healthcare contractor to Celtic's insureds. That representation was material to Celtic because it determined the amount that Celtic would pay to TeamHealth for the service.



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137. TeamHealth utilized upcoding to increase payments on a large proportion of the health insurance claims that it submitted to Celtic from 2014 to present. On TeamHealth's upcoded health insurance claims, the CPT code appearing on the claim did not in fact, accurately represent the service provided to Celtic's insureds, and/or TeamHealth billed for services provided by a physician's assistant as if the service was provided by a doctor. For example, each time TeamHealth submitted to Celtic health insurance claims with the CPT code 99285, it represented that the problem was high severity and posed an immediate significant threat to life or physiologic function. As detailed above, in thousands of cases, those representations were false.

138. TeamHealth made these false and fraudulent representations to Celtic on a regular and recurring basis since at least 2014, although Celtic did not discover the fraudulent nature of the representations until 2020.

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139. Because of the large volume of representations in question, and because it is not possible without discovery to identify which specific TeamHealth health insurance claims contained misrepresentations without access to the medical records in question, it is not possible at this point to precisely identify each instance of misrepresentation by TeamHealth, as the necessary facts are within TeamHealth's exclusive control.

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140. TeamHealth made representations to Celtic in the regular course of TeamHealth's business. Coding and submission of health insurance claims for emergency room services to Celtic and other insurance companies and patients is the primary source of revenue for TeamHealth and is at the core of TeamHealth's regular business.

141. TeamHealth intended that Celtic would rely on TeamHealth's representations in the course of Celtic's own business. TeamHealth knew that Celtic would rely on the CPT codes



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and other information that TeamHealth submitted in its health insurance claims, and would use that information to determine the amount of payment to make to TeamHealth.

142. TeamHealth had a duty to exercise reasonable care in obtaining information about its business and in communicating that information to others, like Celtic, who TeamHealth knew would rely on that information.

143. TeamHealth breached its duty of reasonable care by creating tens of thousands of health insurance claims that contained higher CPT codes than the underlying medical services warranted, and by transmitting those health insurance claims to Celtic without ensuring that the CPT code accurately described the level of service provided or that the claim correctly identified the healthcare contractor who provided the service.

144. Celtic reasonably relied on TeamHealth's representations in making payment to TeamHealth for services rendered to Celtic's insureds. Because Celtic does not typically have access to patients' underlying medical records, it relies on TeamHealth's representations regarding the level of service performed to determine the amount of payment to TeamHealth. Celtic only discovered the falsity of TeamHealth's representations to Celtic on Affordable Care Act claims through discovery in separate litigation.

145. Celtic was injured by its reasonable reliance on TeamHealth's false representations in an amount to be determined at trial, specifically, through the difference between the amount that Celtic paid based on the CPT codes that TeamHealth presented in tens of thousands of health insurance claims, and the amount that Celtic would have paid if TeamHealth had instead submitted health insurance claims that accurately identify the level of service and the type of provider.

146. Because TeamHealth was reckless and its conduct was egregious, Celtic is entitled to punitive damages.

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## V. COUNT V: TENNESSEE CONSUMER PROTECTION ACT

147. Celtic incorporates by reference the allegations in each of the preceding paragraphs as if fully set forth herein.

148. The Tennessee Consumer Protection Act (TCPA), Tenn. Code Ann. §§ 47-18-101 et seq., is designed "[t]o protect consumers and legitimate business enterprises from those who engage in unfair or deceptive acts or practices in the conduct of any trade or commerce in part or wholly within this state." Tenn. Code Ann. § 47-18-102(2).

149. Under that statute, "[a]ny person who suffers an ascertainable loss of money or property, real, personal, or mixed, or any other article, commodity, or thing of value wherever situated, as a result of the use or employment by another person of an unfair or deceptive act or practice declared to be unlawful by this part, may bring an action individually to recover actual damages." Tenn. Code Ann. § 47-18-109(a)(1).

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150. The TCPA defines "[t]rade, commerce, or consumer transaction" to mean "the advertising, offering for sale, lease or rental, or distribution of any goods, services, or property, tangible or intangible, real, personal, or mixed, and other articles, commodities, or things of value wherever situated." Tenn. Code Ann. § 47-18-109(a)(11). The statute defines "[s]ervices" to include "any work, labor, or services including services furnished in connection with the sale or repair of goods or real property or improvements thereto." *Id.* § 47-18-109(a)(10). By contracting with hospitals to provide ER staffing and related services, and submitting insurance claims to insurers for payment, TeamHealth engaged in "[t]rade, commerce, or consumer transaction[s]" within the meaning of the TCPA. TeamHealth's activities, including its coding practices, took place at its corporate offices in Tennessee.

151. TeamHealth engaged in unfair or deceptive acts or practices in the conduct of trade or commerce, including but not limited to the following:



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a. TeamHealth systematically engages in upcoding, or billing for a higher level of service than was actually provided by its healthcare contractors;

b. TeamHealth systematically bills for services performed by physician's assistants as if the relevant service were performed by a doctor; and

c. TeamHealth uses an "out-of-network strategy" to try to collect "billed charges" that are grossly inflated and are often eight, nine, or ten times the amount allowed by Medicare, and bear no resemblance to the cost of providing the service.

152. TeamHealth's conduct falls within the unfair or deceptive acts or practices defined in the TCPA, including but not limited to the following:

a. "Representing that goods or services have . . . characteristics . . . benefits or quantities that they do not have" (Tenn. Code Ann. § 47-18-104(b)(5));

b. "Representing that goods or services are of a particular standard, quality or grade, or that goods are of a particular style or model, if they are of another" (Tenn. Code Ann. § 47-18-104(b)(7));

c. "Representing that a service, replacement or repair is needed when it is not" (Tenn. Code Ann. § 47-18-104(b)(13).

153. As a result of TeamHealth's use or employment of unfair or deceptive acts or practices, Celtic has suffered an ascertainable loss of money or property. For instance, TeamHealth's systematic upcoding, misrepresentation of services as performed by doctors instead of physician's assistants, and billing of high out-of-network charges caused Celtic to pay substantially more on TeamHealth's insurance claims than it would have paid had TeamHealth not



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engaged in these practices. TeamHealth's conduct ultimately harmed insureds by exerting upward pressure on insurance premiums, cost-sharing obligations, and healthcare costs in general.

154. As a result of TeamHealth's conduct, Celtic is entitled to recover actual damages in an amount to be determined at trial.

155. TeamHealth's use or employment of the unfair or deceptive acts and practices constituted willful and knowing violations of the TCPA. In particular, TeamHealth knew the services that its healthcare contractors actually performed based on the medical charts completed by the providers. By assigning higher-level billing codes than those services merited and submitting those codes to Celtic for payment, TeamHealth knowingly and willfully caused Celtic to pay more for the ER services than was warranted. TeamHealth intentionally misrepresented the services provided to secure greater payments, knowing that it would be difficult for Celtic to discover the upcoding without the underlying medical records. TeamHealth's systematic scheme to extract higher payments from Celtic, other insurance companies, and CMS reflects bad faith. Based on these knowing and willful violations of the TCPA, Celtic is entitled to have its actual damages trebled pursuant to Tenn. Code Ann. § 47-18-109(a)(3) and § 47-18-109(a)(4).

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156. Celtic is entitled to reasonable attorney's fees and costs pursuant to Tenn. Code Ann. § 47-18-109(e)(1).

## VI. COUNT VI: FRAUDULENT INSURANCE ACT — Tennessee Insurance Law

157. Celtic incorporates by reference the allegations in each of the preceding paragraphs as if fully set forth herein.

158. The Tennessee Insurance Law, Tenn. Code. Ann. §§ 56-53-101 et seq., makes it "unlawful for any person [including a company] to commit . . . a fraudulent insurance act." Tenn. Code Ann. § 56-53-102(b).



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159. "Any person injured in the person's business or property" by a fraudulent insurance act can sue "in any appropriate court having jurisdiction" to recover damages. Tenn. Code Ann. § 56-53-107(b)(1).

160. An entity commits a "fraudulent insurance act" when it "knowingly and with intent to defraud, and for the purpose of depriving another of property or for pecuniary gain," commits any of the enumerated acts. Tenn. Code Ann. § 56-53-102(a). The statutory list includes "[p]resent[ing] . . . on behalf of an insured . . . to an insurer . . . in connection with an insurance transaction . . . any information that contains false representations as to any material fact . . . concerning . . . [a] claim for payment or benefit pursuant to any insurance policy." Tenn. Code Ann. § 56-53-102(a).

161. When TeamHealth submitted health insurance claims for ER services to Celtic, TeamHealth presented, on behalf of Celtic's Affordable Care Act members, claims for payment pursuant to those patients' Affordable Care Act insurance policies. TeamHealth made representations that the CPT code stated on those claims accurately reflected the service provided; that the healthcare contractor who performed the service is accurately identified on the claim, and that TeamHealth was in possession of a signed assignment of benefits form from the member. Those representations were material to Celtic because they determined the amount Celtic would pay to TeamHealth for the services rendered to Celtic's insureds.

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162. TeamHealth upcoded a broad swath of the health insurance claims that it submitted to Celtic. The upcoded claims did not truthfully describe the service provided or the healthcare contractor who performed it. For example, each time that TeamHealth transmitted to Celtic a health insurance claim with the CPT code 99285, TeamHealth represented that the member's



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medical need was of high severity and posed an immediate significant threat to life or physiologic function. As detailed above, in thousands of cases, those representations were knowingly false.

163. TeamHealth made these material false representations to Celtic repeatedly since at least 2014. Celtic, however, did not and could not detect this scheme until this year, when a judge granted Celtic's motion to compel TeamHealth to produce medical records underlying health insurance claims at issue in that case. Celtic presently cannot identify every specific instance of fraud by TeamHealth, because Celtic does not have in its possession the vast majority of medical records underlying the hundreds of thousands of health insurance claims that TeamHealth has submitted to Celtic in the past seven or more years. These medical records remain in TeamHealth's exclusive control, although Celtic will seek them in discovery in this case.

164. TeamHealth knew that its representations were false because it had access to the medical records for each patient and thus was aware that its upcoded health insurance claims mischaracterize the services actually provided. TeamHealth also knew that its representations were false because TeamHealth's false representations were but one facet of TeamHealth's policies and procedures designed to maximize revenue through systematic upcoding and overbilling, as described in detail above.

165. TeamHealth has sent tens of thousands of upcoded health insurance claims to Celtic from TeamHealth's corporate offices over the past seven or so years. TeamHealth's longstanding practice of upcoding and misrepresenting services on health insurance claims demonstrates that TeamHealth intended to defraud Celtic through systematic upcoding and overbilling. TeamHealth engaged in this fraud for pecuniary gain because it stood to reap millions in higher payments that correspond to higher billing codes.

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166. Celtic suffered economic injury because TeamHealth's deceit induced Celtic to make payments that exceeded the amount that it would have paid had the claims been properly coded. Therefore, Celtic is entitled to a "[r]eturn of any profit, benefit, compensation or payment" that TeamHealth obtained from its fraudulent insurance acts and "[a]ll other economic damages directly resulting from" these acts. *See* Tenn. Code Ann. § 56-53-107(b)(1)(A), (C).

167. Because TeamHealth consistently utilized upcoding to inflate insurance claims, it had a pattern and practice of fraudulent insurance acts. Accordingly, Celtic is entitled to threefold the economic damages attributable to TeamHealth's fraud. *See* Tenn. Code Ann. § 56-53-107(c).

168. Celtic is also entitled to reasonable attorneys' fees and related legal expenses, reasonable fees incurred in investigating TeamHealth's violations, and a penalty within the prescribed range of $100–$10,000 per violation that the Court deems just. *See* Tenn. Code Ann. § 56-53-107(b)(1)(B), (D), (E).

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## VII. COUNT VII: FRAUDULENT INSURANCE ACT, ATTEMPT — Tennessee Insurance Law

169. Celtic incorporates by reference the allegations in each of the preceding paragraphs as if fully set forth herein.

170. The Tennessee Insurance Law makes it "unlawful for any person to . . . attempt to commit . . . a fraudulent insurance act." Tenn. Code Ann. § 56-53-102(b).

171. "Any person injured in the person's business or property" by an attempted fraudulent insurance act may sue for damages. Tenn. Code Ann. § 56-53-107(b)(1).

172. A person commits a "fraudulent insurance act" when it "knowingly and with intent to defraud, and for the purpose of depriving another of property or for pecuniary gain," "[p]resents . . . on behalf of an insured . . . to an insurer . . . in connection with an insurance transaction . . .



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any information that contains false representations as to any material fact . . . concerning . . . [a] claim for payment or benefit pursuant to any insurance policy." Tenn. Code Ann. § 56-53-102(a).

173. TeamHealth submitted thousands of false and fraudulent insurance claims to Celtic. TeamHealth billed and attempted to collect its entire "billed charges," knowing that the billed charges reflected TeamHealth's upcoding, which misrepresented the true complexity or severity of the patient encounter, and who provided the service. This fraudulent conduct, spanning at least the past seven or more years, constituted substantial steps toward the consummation of a fraudulent scheme designed to extract unearned payments from Celtic. TeamHealth's course of action at all times coincided with its specific intent to commit such fraudulent insurance acts. By submitting upcoded claims knowing that they misrepresented the services actually provided and who provided the service, TeamHealth specifically intended to deceive Celtic into paying greater reimbursements than were warranted.

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174. TeamHealth's attempted fraudulent insurance acts have directly and proximately injured Celtic in its business or property. TeamHealth's deceit induced Celtic to pay substantially more money to TeamHealth than Celtic would have paid had TeamHealth not submitted fraudulent insurance claims. Therefore, Celtic is entitled to a "[r]eturn of any profit, benefit, compensation or payment" that TeamHealth obtained from its attempted fraudulent insurance acts and "[a]ll other economic damages directly resulting from" these attempts. *See* Tenn. Code Ann. § 56-53-107(b)(1)(A), (C).

175. Because TeamHealth consistently deployed the two variants of upcoding to inflate claims, it had a longstanding pattern and practice of attempted fraudulent insurance acts. Therefore, Celtic is entitled to threefold the economic damages that TeamHealth attempted to cause through its fraudulent acts. *See* Tenn. Code Ann. § 56-53-107(c).



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176. Celtic is also entitled to reasonable attorneys' fees and related legal expenses, reasonable fees incurred in investigating TeamHealth's violations, and a penalty within the statutory range of $100–$10,000 for each attempted fraudulent insurance act. *See* Tenn. Code Ann. § 56-53-107(b)(1)(B), (D), (E).

**VIII. COUNT VIII: UNLAWFUL INSURANCE ACT — Tennessee Insurance Law**

177. Celtic incorporates by reference the allegations in each of the preceding paragraphs as if fully set forth herein.

178. Celtic pleads this claim in the alternative to Counts VI and VII.

179. The Tennessee Insurance Law makes it "unlawful for any person to commit . . . an unlawful insurance act." Tenn. Code Ann. § 56-53-103(b).

180. "Any person injured in the person's business or property" by an unlawful insurance act may sue for damages. Tenn. Code Ann. § 56-53-107(a)(1).

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181. Unlawful insurance acts include knowingly or recklessly, and with an "intent to induce reliance," "[p]resent[ing] . . . on behalf of an insured . . . to an insurer" false representations of material fact about "[a] claim for payment or benefit pursuant to any insurance policy." Tenn. Code Ann. § 56-53-103(a)(1).

182. When TeamHealth submitted health insurance claims for ER services to Celtic, TeamHealth presented, on behalf of Celtic's Affordable Care Act members, claims for payment pursuant to those patients' Affordable Care Act insurance policies. TeamHealth made representations that the CPT code stated on those claims accurately reflected the service provided; that the healthcare contractor who performed the service is accurately identified on the claim, and that TeamHealth was in possession of a signed assignment of benefits form from the member.



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Those representations were material to Celtic because they determined the amount Celtic would pay to TeamHealth for the services rendered to Celtic's insureds.

183. TeamHealth upcoded a broad swath of the health insurance claims that it submitted to Celtic. The upcoded claims did not truthfully describe the service provided or the healthcare contractor who performed it. For example, each time that TeamHealth transmitted to Celtic a health insurance claim with the CPT code 99285, TeamHealth represented that the member's medical need was of high severity and posed an immediate significant threat to life or physiologic function. As detailed above, in thousands of cases, those representations were false.

184. TeamHealth has routinely made these material false representations to Celtic for at least the past seven years. Celtic did not and could not discover them until separate litigation this year exposed some of the medical records that TeamHealth had sought to conceal. Celtic presently cannot identify every specific instance of unlawful insurance acts by TeamHealth, because TeamHealth maintains exclusive control over the vast majority of the medical records underlying the claims that it has submitted to Celtic for Affordable Care Act members.

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185. TeamHealth knew that its representations were false, or at least acted with reckless disregard for their falsity, because the medical records it received from its healthcare contractors did not support the billing codes that TeamHealth assigned. TeamHealth intended to induce Celtic to rely on its false representations because it sent the upcoded health insurance claims, without the medical records, knowing that Celtic would pay the claim without the ability to reconcile the claim with the medical record.

186. Celtic endured economic injury from millions of excess payments to TeamHealth. Celtic would have paid less if TeamHealth had not upcoded the claims at issue. Thus, Celtic is



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entitled to a return of TeamHealth's ill-gotten profit, benefit, or payment and to reasonable attorneys' fees and related legal expenses. *See* Tenn. Code Ann. § 56-53-107(a)(1).

## IX. COUNT IX: UNLAWFUL INSURANCE ACT, ATTEMPT — Tennessee Insurance Law

187. Celtic incorporates by reference the allegations in each of the preceding paragraphs as if fully set forth herein.

188. Celtic pleads this claim in the alternative to Counts VI and VII.

189. The Tennessee Insurance Law makes it "unlawful for any person . . . to attempt to commit . . . an unlawful insurance act." Tenn. Code Ann. § 56-53-103(b).

190. "Any person injured in the person's business or property" by an attempted unlawful insurance act may sue for damages. Tenn. Code. Ann. § 56-53-107(a)(1).

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191. Unlawful insurance acts include knowingly or recklessly, and with an "intent to induce reliance," "[p]resent[ing] . . . on behalf of an insured . . . to an insurer" false representations of material fact about "[a] claim for payment or benefit pursuant to any insurance policy." Tenn. Code Ann. § 56-53-103(a)(1).

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192. TeamHealth submitted thousands of materially false insurance claims to Celtic. TeamHealth billed and attempted to collect its entire "billed charges," knowing that the billed charges misrepresented the complexity or severity of the patient encounter or without a reasonable belief in the truth of the assigned code or provider identifier on the claims. This course of action, spanning at least the past seven or more years, TeamHealth's conduct constituted substantial steps toward the commission of an unlawful scheme that would have caused Celtic to pay millions more in unwarranted payments to TeamHealth. TeamHealth pursued this course of action with the specific intent to commit such unlawful insurance acts. By submitting upcoded claims knowing



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or recklessly disregarding that they misrepresented the services actually provided and/or who performed the services, TeamHealth specifically intended to induce Celtic to rely on those claims and make greater payments to TeamHealth than was warranted.

193. TeamHealth's attempted unlawful insurance acts have directly and proximately injured Celtic in its business or property. By recklessly submitting insurance claims bearing inflated CPT codes and misrepresenting information about who provided the service, TeamHealth caused Celtic to pay substantially more to TeamHealth than it would have had it known the truth about the services provided. Therefore, Celtic is entitled to a return of any profit, benefit, or payment that TeamHealth extracted from these attempts and to reasonable attorneys' fees and related legal expenses. *See* Tenn. Code Ann. § 56-53-107(a)(1).

## X. COUNT X: UNJUST ENRICHMENT — Tennessee Common Law

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194. Celtic incorporates by reference the allegations in each of the preceding paragraphs as if fully set forth herein.

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195. Celtic has repeatedly conferred benefits on TeamHealth, namely, payment for services purportedly rendered by TeamHealth to Celtic's insureds. TeamHealth received and appreciated those benefits; it was aware that Celtic was making payments to it for services purportedly rendered.

196. Retention of this benefit by TeamHealth would be unjust and inequitable, because the amount of the payment in many cases greatly exceeds the value of the service for which it was supposedly made, namely, provision of medical services to Celtic's insureds.

197. Celtic is not in contractual privity with TeamHealth. There is therefore no means for Celtic to secure contractual recovery of the benefits it has conferred on TeamHealth. Any attempt to seek recovery of Celtic's losses from the parties with whom Celtic is in contractual



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privity, i.e., Celtic's insureds or the hospitals, would be unjust because Celtic's insureds who seek treatment in emergency rooms have little control over which ER doctor they see and have no control over how their claims are coded, and neither the patients nor the hospitals receive the overpayment that TeamHealth extracted from Celtic via its coding schemes.

**PRAYER FOR RELIEF**

**WHEREFORE**, Celtic respectfully requests that the Court grant the following relief:

(i) Enter judgment in favor of Celtic on all counts of this Complaint;

(ii) Award Celtic money damages, including compensatory damages and punitive/exemplary damages, in an amount to be proven at trial, of at least $100,000,000, including but not limited to:

a. treble damages pursuant to RICO, 18 U.S.C. § 1965(c), or as otherwise permitted by law;

b. threefold the economic damages that TeamHealth attempted to cause Celtic through TeamHealth's fraudulent acts pursuant to Tenn. Code Ann. § 56-53-107(c);

c. a penalty within the statutory range of $100–$10,000 for each fraudulent insurance claim that TeamHealth submitted to Celtic pursuant to Tenn. Code Ann. § 56-53-107(b)(1)(E);

(iii) Enter a permanent injunction requiring TeamHealth to alter its current policies regarding upcoding, retrain its coding staff to properly code medical claims rather than systematically upcode medical claims, and submit to a regular, at least yearly, audit of its coding practices by an independent monitor, with all costs of such audit to be paid by TeamHealth;

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(iv) Award Celtic its costs, expenses, and reasonable attorney's fees incurred in this action, pursuant to 18 U.S.C. § 1965(c), Tenn. Code Ann. § 56-53-107(a)(1)(B), Tenn. Code Ann. § 56-53-107(b)(1)(B), or as otherwise permitted by law;

(v) Award Celtic pre- and post-judgment interest to the maximum extent permitted by law;

(vi) Award such other relief as this Court deems just and proper.

**DEMAND FOR JURY TRIAL**

Celtic requests a jury trial of all issues properly triable by jury.

Dated: December 10, 2020

Respectfully submitted,

WILLIAMS & CONNOLLY LLP

By: */s/ Steven M. Cady*

Brendan V. Sullivan, Jr.*
C. Bryan Wilson*
Steven M. Cady*
725 Twelfth Street, N.W.
Washington, D.C. 20005
Telephone: (202) 434-5000
bsullivan@wc.com
bwilson@wc.com
scady@wc.com
* Pro hac vice motions forthcoming

BROCK SHIPE KLENK PLC

By: */s/ W. Edward Shipe*

W. Edward Shipe (BPR #023887)
265 Brookview Centre Way, Suite 604
Knoxville, Tennessee 37919
Telephone: (865) 338-9700
eshipe@bskplc.com

*Attorneys for Plaintiff Celtic Insurance Company*



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# EXHIBIT 13

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EXHIBIT 13

KRISTEN T. GALLAGHER (NSBN 9561)
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 Plaintiff Fremont Emergency Services (Mandavia), Ltd.*

**UNITED STATES DISTRICT COURT**

**DISTRICT OF NEVADA**

| | |
|---|---|
| FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation,<br><br>Plaintiff,<br><br>vs.<br><br>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; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20,<br><br>Defendants. | Case No.: 2:19-cv-00832-JAD-VCF<br><br>**FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS** |

Pursuant to Rules 26 and 34 of the Federal Rules of Civil Procedure plaintiff Fremont Emergency Services (Mandavia), Ltd. ("Fremont") serves the following First Set of Requests for Production of Documents ("Document Requests") to defendants United HealthCare Insurance Company ("UHCIC"), United HealthCare Services, Inc. ("UHC Services"), UMR, Inc. ("UMR"), Oxford Health Plans, Inc. ("Oxford" and collectively the "UH Parties"), Sierra Health and Life



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Insurance Company, Inc. ("Sierra"), Sierra Health-Care Options, Inc. ("Sierra Options") and Health Plan of Nevada, Inc. ("HPN" and with "Sierra and Sierra Options, the "Sierra Affiliates" and collectively with the UH Parties, "United HealthCare") and asks that United HealthCare respond in writing within thirty (30) days of the date of service, to McDonald Carano LLP, 2300 West Sahara Avenue, Suite 1200, Las Vegas, Nevada 89102. These Document Requests are continuing in nature and Defendant must timely supplement the answers to them under Fed. R. Civ. P. 26(e) whenever a response is in some material respect incomplete or incorrect.

**DEFINITIONS**

1. "Communicate" means every manner or means of disclosure or transfer or exchange of information whether orally, by document or otherwise, and whether face to face, in a meeting, by telephone or other electronic media, mail, personal delivery or otherwise.

2. "Communication" means the transfer of information from a person or entity, place, location, format, or medium to another person or entity, place, location, format, or medium, without regard to the means employed to accomplish such transfer of information, but including without limitation oral, written and electronic information transfers. Each such information transfer, if interrupted or otherwise separated in time, is a separate communication.

3. "Document" is defined to be synonymous in meaning and equal or exceeding in scope to the usage of this term in Fed. R. Civ. P. 34(a). It includes images, words and symbols that are electronically stored and which, if printed on paper, would be the text of a document, as well as metadata contained within particular electronic files. It also means all written or graphic matter of every kind or description however produced or reproduced whether in draft, in final, original or reproduction, signed or unsigned, whether or not now in existence, and regardless of whether approved, sent, received, redrafted or executed, and includes without limiting the generality of its meaning all correspondence, telegrams, notes, e-mail, video or sound recordings of any type of communication(s), conversation(s), meeting(s), or conference(s), minutes of meetings, memoranda, interoffice communications, intra office communications, notations, correspondence, diaries, desk calendars, appointment books, reports, studies, analyses, summaries, results of investigations or tests, reviews, contracts, agreements, working papers, tax

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returns, statistical records, ledgers, books of account, vouchers, bank checks, bank statements, invoices, receipts, records, business records, photographs, tape or sound recordings, maps, charts, photographs, plats, drawings or other graphic representations, logs, investigators' reports, stenographers' notebooks, manuals, directives, bulletins, computer data, computer records, or data compilations of any type or kind of material similar to any of the foregoing however denominated and to whomever addressed. "Document" shall include but is not limited to any electronically stored data on magnetic or optical storage media as an "active" file (readily readable by one or more computer applications or forensic software); any "deleted" but recoverable electronic files on said media; any electronic file fragments (files that have been deleted and partially overwritten with new data); and slack (data fragments stored randomly from random access memory on a hard drive during the normal operation of a computer [RAM slack] or residual data left on the hard drive after new data has overwritten some but not all of the previously stored data. "Document" shall exclude exact duplicates when originals are available but shall include all copies made different from originals by virtue of any writings, notations, symbols, characters, impressions or any marks thereon.

4. Data iSight is the trademark of an analytics service owned by National Care Network, LLC. Data iSight and National Care Network, LLC are collectively referred to as "Data iSight."

5. "Fremont" shall mean and refer to Fremont Emergency Services (Mandavia), Ltd. and/or any past or present agents, representatives, employees, partners, principals, members, assigns, predecessors-in-interest, successors-in-interest, affiliates and every person acting or purporting to act, or who has ever acted or purported to act, on its behalf.

6. "Defendants," "You," or "Your" shall mean and refer to Defendants United HealthCare Insurance Company, United HealthCare Services, Inc., UMR, Inc., Oxford Health Plans, Inc., Sierra Health and Life Insurance Company, Inc., Sierra Health-Care Options, Inc. and Health Plan of Nevada, Inc. and/or any past or present agents, representatives, employees, partners, principals, members, assigns, predecessors-in-interest, successors-in-interest, and every person acting or purporting to act, or who has ever acted or purported to act, on their behalf.

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7. "UH Parties" means and refers to defendants United HealthCare Insurance Company, United HealthCare Services, Inc., UMR, Inc. and Oxford Health Plans, Inc.

8. "Sierra Affiliates" means and refers to defendants Sierra Health and Life Insurance Company, Inc., Sierra Health-Care Options, Inc., and Health Plan of Nevada, Inc.

9. "Lawsuit" shall mean and refer to the lawsuit styled *Fremont Emergency Services (Mandavia), Ltd. v. United HealthCare Insurance Company, et al.* filed in the Eighth Judicial District Court, Clark County, Nevada, Case No. A-19-792978-B and removed to the United States District Court, D. Nevada, Case No. 2:19-cv-00832-JAD-VCF.

10. A "claim" means any billing instrument or request for reimbursement by a Provider for medical services provided.

11. "CLAIM" or "CLAIMS" means those claims for reimbursement for Emergency Services and Care or Nonemergency Services and Care provided by Fremont to Your Plan Members for dates of service on or after July 1, 2017 (UH Parties) and on or after March 1, 2019 (Sierra Affiliates).

12. "Emergency Services and Care" means medical screening, examination, and evaluation by a physician or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists, and if the physician or personnel determines that it does exist, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition within the service capability of a hospital.

13. "Emergency Medicine Services" shall mean and refer to evaluation and management services (described by CPT codes 99281-99285), critical care services (described by CPT codes 99291-92) and the associated procedures performed by Fremont in the State of Nevada.

14. "Emergency Medicine Group" shall mean and refer to any or all groups of physicians, mid-level practitioners and other healthcare providers that staff hospital emergency departments, observations units and urgent care clinics in the State of Nevada, whether the group is structured as a professional corporation, a limited liability corporation, partnership, or otherwise.

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15. "Emergency Department Services" shall mean all services performed in the emergency department of a hospital in the State of Nevada by a hospital, physicians of any specialty (not limited to emergency medicine physicians), nurses or any healthcare providers.

16. "Nonemergency Services and Care" means medical services and care which are not Emergency Services and Care.

17. "Non-Participating Provider" or "Non-Network Provider" means a healthcare provider who has not been designated by You as a "participating" or "network" provider.

18. "Participating Provider" or "Network Provider" means a healthcare provider who has an agreement with You as an independent contractor or otherwise, or who has been designated by You, to provide services to Plan Members.

19. "Plan" means any health benefit product or program, including but not limited to an HMO, an Exclusive Provider Organization ("EPO") or Preferred Provider Organization ("PPO") product or program, issued, administered, or serviced by You.

20. "Plan Member" means an individual covered by or enrolled in a Plan.

21. "Provider" means any physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed to do so in the state where those services are furnished.

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**INSTRUCTIONS**

1. These Document Requests seek all requested documents that are in Defendant's possession, custody, and/or control, including without limitation, any records depositories or archives.

2. Copies of requested documents that differ from other copies of the document by reason of alterations, margin notes, comments, attached materials, or otherwise shall be considered separate documents and shall be produced separately.

3. Documents that are physically attached to, segregated and/or separated from other documents, whether by inclusion in binders, files, sub files, or by use of dividers, tabs, or any other method, shall be left so attached, segregated, and/or separated when produced, and shall be retained in the order in which they are maintained, in the file where they are found.



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4. If you contend that any document requested to be produced, or any part thereof, is protected from discovery by the attorney-client privilege, work product doctrine, or some other ground or privilege or immunity, as required under Rule 26(b)(5) of the Federal Rules of Civil Procedure, produce a log that identifies each document withheld and provides at a minimum the following information:

a. the place, date, and manner of preparation or other recording of the document;

b. the title and subject matter of the document;

c. the identity and position of the author, the addressee, and all recipients of the document; and

d. a statement of (i) the nature of the legal privilege claimed or other reason for withholding the document and (ii) the factual basis for that claim of privilege or other reason for withholding, including the facts establishing any claim of privilege, the facts showing that the privilege has not been waived, the status of the person claiming the privilege, and a statement as to whether the contents of the document are limited to legal advice or contain other subject matter.

5. For each document from which portions were withheld pursuant to instruction 4, identify and produce all other portions of the document not so withheld.

6. Scope of Answers. In answering these Document Requests, you are requested to furnish all information available to you, however obtained, including hearsay, information known by you or in your possession or appearing in your records, information in the possession of your attorneys, your investigators, and all persons acting on your behalf, and not merely the information known of your own personal knowledge.

7. Qualification of Answers. If your answer is in any way qualified, please state the exact nature and extent of the qualification.

8. If additional information or documents become known to Defendant regarding any of these Document Requests following the initial response and submission to Plaintiff, supplementation of the response with such information is required.

9. For each document produced, identify the specific document request number or numbers to which the document is responsive.

10. All documents are to be produced as they are kept in the usual course of business including any labels, file markings, or similar identifying features, or shall be organized and

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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labeled to correspond to the categories requested herein. If there are no documents in response to a particular request, or if you withhold any responsive documents or categories of documents based on any objections, You shall state so in writing.

11. Where a request seeks the production of electronically stored information ("ESI"), that information must be produced in its native format with corresponding load files containing the document's text and all available metadata. For purposes of these discovery requests, "native format" means a file saved in the format designated by the original application used to create it.

12. If you object to any Request in part, you shall respond fully to the extent not objected to, and set forth specifically the grounds upon which the objection is based.

13. If you cannot answer a Request fully after exercising due diligence to secure the documents requested, so state and respond to the extent possible, specifying your inability to respond to the remainder, the reasons therefore, the steps taken to secure the documents that were not produced, and stating whatever information or knowledge you have concerning the missing documents. Please also identify the person you believe to have possession of the missing documents, and the facts upon which you base your response.

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PHONE 702.873.4100 • FAX 702.873.9966

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## RULES OF CONSTRUCTION

1. The terms "relate to," "related to," "relating to," "relative to," and "in relation to," include without limitation "refer to," "summarize," "reflect,' "constitute," "concern," "contain," "embody," "mention," "show," "comprise," "evidence," "discuss," "describe," or "pertaining to."

2. The term "concerning" means and includes without limitation "regarding," "pertaining to," "reflecting," "referring to," "relating to," "containing," "embodying," "mentioning," "evidencing," "constituting," or "describing."

3. The use of the masculine gender, as used herein, also means the feminine, or neuter, whichever makes a discovery interrogatory more inclusive.

4. The words "and" and "or" shall be construed conjunctively or disjunctively, whichever makes a discovery interrogatory more inclusive.

5. The use of the singular form of any word includes the plural and vice versa.

6. The terms "person or entity" and "persons or entities" mean any individual, firm,



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corporation, joint venture, partnership, association, fund, other organization, or any collection or combination thereof.

**REQUESTS FOR PRODUCTION OF DOCUMENTS**

**REQUEST FOR PRODUCTION NO. 1:**

Produce all Documents and/or Communications with the Nevada Division of Insurance and/or Nevada Insurance Commissioner relating to or concerning NRS 679B.152.

**REQUEST FOR PRODUCTION NO. 2:**

Produce any and all Documents and/or Communications regarding, discussing, or referring to NRS 679B.152

**REQUEST FOR PRODUCTION NO. 3:**

Produce any and all Documents and/or Communications between You and Fremont regarding any of the CLAIMS.

**REQUEST FOR PRODUCTION NO. 4:**

Produce all Documents and/or Communications regarding Your adjudication and/or payment of each CLAIMS that Fremont submitted to You for payment between July 1, 2017, and the present.

**REQUEST FOR PRODUCTION NO. 5:**

Produce any and all Documents and/or Communications relating to Your determination and/or calculation of the allowed amount and reimbursement for any of the CLAIMS, including the following: (i) the method by which the allowed amount and reimbursement for the Claim was calculated; (ii) the total amount You allowed and agreed to pay; (iii) any contractual or other allowance taken; and (iv) the method, date, and final amount of payment.

**REQUEST FOR PRODUCTION NO. 6:**

Produce any and all Documents and/or Communications relating to Your decision to reduce payment for any CLAIM.

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2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
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**REQUEST FOR PRODUCTION NO. 7:**

Produce any and all Documents and/or Communications supporting or relating to Your contention or belief that You are entitled to pay or allow less than Fremont's full billed charges for any of the CLAIMS.

**REQUEST FOR PRODUCTION NO. 8:**

If you contend that any course of prior business dealing(s) by and between You and Fremont entitle(s) You to pay less than Fremont's full billed charges for any of the CLAIMS, or is otherwise relevant to the amounts paid for any of the CLAIMS, produce any Documents and/or Communications relating to any such prior course of business dealing(s).

**REQUEST FOR PRODUCTION NO. 9:**

If you contend that any agreement(s) by and between You and Fremont entitles You to pay less than Fremont's full billed charges for any of the CLAIMS, or is otherwise relevant to the amounts paid for any of the CLAIMS, produce any Documents and/or Communications relating to any such agreement(s).

**REQUEST FOR PRODUCTION NO. 10:**

Produce any and all Documents and/or Communications relating to the methodology You currently use, or used during calendar or Plan years 2016, 2017, 2018 and/or 2019 to determine and/or calculate Your reimbursement of Non-Participating Providers in Nevada for Emergency Medicine Services.

**REQUEST FOR PRODUCTION NO. 11:**

Produce all Documents and/or Communications between You and any third-party, including but not limited to Data iSight, relating to (a) any claim for payment for medical services rendered by Fremont to any Plan Member, or (b) any medical services rendered by Fremont to any Plan Member.

**REQUEST FOR PRODUCTION NO. 12:**

Produce all Documents identifying and describing all products or services Data iSight, provides to You with respect to Your Health Plans issued in Nevada or any other state, including without limitation repricing services provided to You, whether You adjudicated and paid any

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claims in accordance with re-pricing information recommended by Data iSight, and the appeals administration services provided to You.

**REQUEST FOR PRODUCTION NO. 13:**

Produce all Documents and/or Communications concerning, evidencing, or relating to any negotiations or discussions concerning Non-Participating Provider reimbursement rates between You and Fremont, including, without limitation, documents and/or communications relating to the meeting in or around December 2017 between You, including, but not limited to, Dan Rosenthal, John Haben, and Greg Dosedel, and Fremont, where Defendants proposed new benchmark pricing program and new contractual rates.

**REQUEST FOR PRODUCTION NO. 14:**

Produce all Documents regarding rates insurers and/or payors other than You have paid for Emergency Services and Care in Nevada to either or both Participating or Non-Participating Providers from July 1, 2016, to the present.

**REQUEST FOR PRODUCTION NO. 15:**

Produce all Documents and/or Communications, reflecting, analyzing, or discussing the methodology you used to calculate or determine Non-Participating Provider reimbursement rates for Emergency Services in Nevada, including, but not limited to, any documents and/or communications you used or created in the process of calculating and/or determining the prevailing charges, the reasonable and customary charges, the usual and customary charges, the average area charges, the reasonable value, and/or the fair market value for Emergency Services in Clark County.

**REQUEST FOR PRODUCTION NO. 16:**

Produce all Documents that refer, relate or otherwise reflect shared savings programs in Nevada for Fremont's out-of-network claims from July 1, 2017 to present. This request includes, without limitation, contracts with third parties regarding Your shared savings program, amounts invoiced by You to third parties for the shared savings program for Fremont's out-of-network claims, amount You were compensated for the shared savings program for Fremont's out-of-network claims.

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PHONE 702.873.4100 • FAX 702.873.9966

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**REQUEST FOR PRODUCTION NO. 17:**

All Communications between You and any third-party, relating to (a) any CLAIM for payment for medical services rendered by Fremont to any Plan Member, or (b) any medical services rendered by Fremont to any Plan Member.

**REQUEST FOR PRODUCTION NO. 18:**

All documents and/or communications regarding the rational, basis, or justification for the reduced rates for emergency services proposed to Fremont in or around 2017 to Present.

**REQUEST FOR PRODUCTION NO. 19:**

All documents regarding the Provider charges and/or reimbursement rates that You have paid to Participating or Non-Participating Providers from July 1, 2017, to the present in Nevada. Without waiving any right to seek further categories of documentation, at this juncture, Fremont is willing to accept, in lieu of contractual documents, data which is blinded or redacted and/or aggregated or summarized form.

**REQUEST FOR PRODUCTION NO. 20:**

All Documents relied on for the determination of the recommended rate of reimbursement for any CLAIM by Fremont for payment for services rendered to any Plan Member. This request includes, without limitation, all cost data, reimbursement data, and other data and Documents upon which such recommended rates are based.

**REQUEST FOR PRODUCTION NO. 21:**

All Documents relating to Your relationship Data iSight, including any and all agreements between You and Data iSight, and any and all documents that explain the scope and extent of the relationship, Your permitted uses of the data provided by Data iSight, and the services performed by Data iSight.

**REQUEST FOR PRODUCTION NO. 22:**

Produce any and all Documents and/or Communications relating to any analysis of the usual and customary provider charges for similar services in Nevada for Emergency Medicine Services.

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**REQUEST FOR PRODUCTION NO. 23:**

Produce any and all Documents and/or Communications relating to any analysis of any Nevada statutes or guidelines You currently use, or used during calendar or Plan years 2016, 2017, 2018 and/or 2019, to determine and/or calculate Your reimbursement of Non-Participating Providers in Nevada for Emergency Medicine Services.

**REQUEST FOR PRODUCTION NO. 24:**

Produce any and all Documents and/or Communications relating to any analysis of Nevada statutes with regard to the payment of the CLAIMS.

**REQUEST FOR PRODUCTION NO. 25:**

Produce all agreements between You and any Participating Providers in Nevada relating to the provision of Emergency Medicine Services to Plan Members.

**REQUEST FOR PRODUCTION NO. 26:**

Produce any and all Documents and/or Communications regarding the provider charges and/or reimbursement rates that other insurers and/or payors have paid for Emergency Medicine Services in Nevada to either or both participating or non-participating providers from January 1, 2016, to the present, including Documents and/or Communications containing any such data or information produced in a blinded or redacted form and/or aggregated or summarized form.

**REQUEST FOR PRODUCTION NO. 27:**

Produce any and All Documents and/or Communications concerning, evidencing, or relating to any negotiations or discussions concerning non-participating provider reimbursement rates between the UH Parties and Fremont, including negotiations or discussions leading up to any participation agreements or contracts with Fremont in effect prior to July 1, 2017.

**REQUEST FOR PRODUCTION NO. 28:**

Produce any and All Documents and/or Communications concerning, evidencing, or relating to any negotiations or discussions concerning non-participating provider reimbursement rates between the Sierra Affiliates and Fremont, including negotiations or discussions leading up to any participation agreements or contracts with Fremont in effect prior to March 1, 2019.

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PHONE 702.873.4100 • FAX 702.873.9966

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**REQUEST FOR PRODUCTION NO. 29:**

Produce any and all contracts and participation agreements that You have or had with any Emergency Medicine Groups and/or any hospitals or other providers of Emergency Department Services other than Fremont that were in effect at any point from January 1, 2016, through the present, including all fee or rate schedules and amendments and addendums, and all other documents reflecting the agreed-upon terms for reimbursement for any product or service.

**REQUEST FOR PRODUCTION NO. 30:**

Produce any and all Documents and/or Communications between You and any Emergency Medicine Groups and/or any hospitals or other providers of Emergency Department Services other than Fremont occurring at any point from January 1, 2016, through the present relating to negotiations of any reimbursement rates and/or fee schedules for Emergency Medicine Services and/or Emergency Department Services.

**REQUEST FOR PRODUCTION NO. 31:**

Produce any and all Documents and/or Communications regarding Your goals, thoughts, discussions, considerations, and/or strategy regarding reimbursement rates and/or fee schedules for participating Emergency Medicine Groups and/or any hospitals or other providers of Emergency Department Services from January 1, 2015, through the present.

**REQUEST FOR PRODUCTION NO. 32:**

Produce any and all Documents and/or Communications regarding Your goals, thoughts, discussions, considerations, and/or strategy regarding reimbursement rates and/or fee schedules for non-participating Emergency Medicine Groups and/or any hospitals or other providers of Emergency Department Services from January 1, 2016, through the present.

**REQUEST FOR PRODUCTION NO. 33:**

Produce any and all Documents and/or Communications regarding Your reimbursement rates paid or to be paid to out-of-network Emergency Medicine Groups and/or complaints about Your level of payment for Emergency Medicine Services and/or Emergency Department Services received from out-of-network providers.

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**REQUEST FOR PRODUCTION NO. 34:**

Produce any and all Documents and/or Communications regarding the impact, if any, that reimbursement rates paid by You to non-participating providers have had on profits You earned and/or premiums You charged with respect to one or more of Your commercial health plans offered in the State of Nevada from 2016 to the present.

**REQUEST FOR PRODUCTION NO. 35:**

Produce any and all Documents and/or Communications regarding Your reimbursement policies for non-participating providers considered or adopted, effective January 1, 2016, to the present.

**REQUEST FOR PRODUCTION NO. 36:**

Produce any and all Documents and/or Communications regarding or reflecting the average or typical rate of payment, or an aggregation, summary or synopsis of those payments, that You allowed from January 1, 2016, to the present for all or any portion of the Emergency Medicine Services and/or Emergency Department Services rendered to Your Plan Members covered under any plan You offer in Nevada.

**REQUEST FOR PRODUCTION NO. 37:**

Produce any and all Documents and/or Communications concerning Emergency Medicine Services and/or Emergency Department Services You published, provided or made available to either Emergency Medicine Groups or Your Plan Members in Nevada from 2016 to the present concerning Your reimbursement of out-of-network services.

**REQUEST FOR PRODUCTION NO. 38:**

Produce any and all Documents and/or Communications concerning Your adjudication and/or payment of each claim for Emergency Medicine Services and/or Emergency Department Services that either participating or non-participating Emergency Medical Groups and/or any hospitals or other providers of Emergency Department Services other than Fremont submitted to You for payment between January 1, 2016, and the present.

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**REQUEST FOR PRODUCTION NO. 39:**

Produce any and all Documents and/or Communications reflecting any policies, procedures, and/or protocols that You contend governs the appeal of Your adjudication and/or payment decision with respect to one or more of the CLAIMS.

**REQUEST FOR PRODUCTION NO. 40:**

Produce any and all Documents and/or Communications regarding any appeals of adverse determinations, disputes of payment, or any submission of clinical information concerning the CLAIMS.

**REQUEST FOR PRODUCTION NO. 41:**

Produce any and all Documents and/or Communications regarding any challenges by any other non-participating Emergency Medicine Group and/or any non-participating hospital or other non-participating provider of Emergency Department Services of the appropriateness of the reimbursement rates paid by You for Emergency Medicine Services and/or Emergency Department Services rendered to Your Plan Members from January 1, 2016, to the present.

**REQUEST FOR PRODUCTION NO. 42:**

Produce any and all Documents and/or Communications regarding, discussing, or referring to any failure by You to attempt to effectuate a prompt, fair, and/or equitable settlement of any CLAIMS.

**REQUEST FOR PRODUCTION NO. 43:**

Produce any and all Documents and/or Communications suggesting that Medicare reimbursement rate for any Emergency Medicine Services is not a measure of either fair market value or the usual and customary rate for such services.

**REQUEST FOR PRODUCTION NO. 44:**

Produce all Documents You reviewed or relied upon in preparing Your responses to Fremont's First Set of Interrogatories.

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PHONE 702.873.4100 • FAX 702.873.9966

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**REQUEST FOR PRODUCTION NO. 45:**

Produce any and all Documents and/or Communications supporting, refuting, or relating to Your affirmative defenses identified in Your Answers to Fremont's First Set of Interrogatories to Defendants.

DATED this 9th day of December, 2019.

McDONALD CARANO LLP

By: /s/ *Kristen T. Gallagher*

Pat Lundvall (NSBN 3761)
Kristen T. Gallagher (NSBN 9561)
Amanda M. Perach (NSBN 12399)
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 Plaintiff Fremont Emergency Services (Mandavia), Ltd.*



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**CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 9th day of December, 2019, I caused a true and correct copy of the foregoing **FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS** to be served via hand delivery as follows:

D. Lee Roberts, Jr., Esq.
Colby L. Balkenbush, Esq.
Josephine E. Groh, Esq.
WEINBERG, WHEELER, HUDGINS,
GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
Telephone: (702) 938-3838
lroberts@wwhgd.corn
cbalkenbush@wwhgd.corn
jgroh@wwhgdcorn

*Attorneys for Defendants UnitedHealthcare Insurance Company, United HealthCare Services, Inc., UMR, Inc., Oxford Health Plans, Inc., Sierra Health and Life Insurance Co., Inc., Sierra Health-Care Options, Inc., and Health Plan of Nevada, Inc.*

/s/ *Marianne Carter*
An employee of McDonald Carano LLP

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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# EXHIBIT 14



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EXHIBIT 14

**RSPN**
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*
WEINBERG, WHEELER, HUDGINS,
GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
Telephone: (702) 938-3838
Facsimile: (702) 938-3864
*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,

vs.

UNITEDHEALTH GROUP, INC., a Delaware corporation; 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; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20,

Defendants.

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

**DEFENDANTS' THIRTEENTH SUPPLEMENTAL RESPONSES TO FREMONT EMERGENCY SERVICES (MANDAVIA) LTD.'S FIRST SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS**



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Defendants UnitedHealth Group, Inc., UnitedHealthcare Insurance Company, United HealthCare Services Inc., UMR, Inc., Oxford Health Plans, Inc., Sierra Health and Life Insurance Co., Inc., Sierra Health-Care Options, Inc., and Health Plan of Nevada, Inc. ("United HealthCare"), by and through their attorneys of the law firm of Weinberg Wheeler Hudgins Gunn & Dial, LLC, hereby submit these supplemental responses to Plaintiff's ("Plaintiff" or "Fremont") First Set of Requests for Production of Documents ("Requests") as follows (**supplemental responses in bold**):

**PRELIMINARY STATEMENT**

Defendants have made diligent efforts to respond to the Requests, but reserve the right to change, amend, or supplement their responses and objections. Defendants also reserve the right to use discovered documents and documents now known, but whose relevance, significance, or applicability has not yet been ascertained. Additionally, Defendants do not waive their right to assert any and all applicable privileges, doctrines, and protections, and hereby expressly state their intent and reserve their right to withhold responsive information on the basis of any and all applicable privileges, doctrines, and protections.

Defendants' responses are made without in any way waiving or intending to waive, but on the contrary, intending to preserve and preserving, their right, in this litigation or any subsequent proceeding, to object on any grounds to the use of documents produced in response to the Request, including objecting on the basis of authenticity, foundation, relevancy, materiality, privilege, and admissibility of any documents produced in response to the Requests.

The documents produced in conjunction with these supplemental responses are being produced subject to the confidentiality and attorneys' eyes only protections permitted pursuant to Section 3(f) of the Stipulation and Order Re: Pending Matters that was entered on May 15, 2020 and pursuant to the terms of Confidentiality and Protective Order that the Parties are currently in the process of negotiating.

Defendants are limiting their responses to the Requests to the reasonable time-frame of July 1, 2017 to present ("Relevant Period") and object to the Requests to the extent that Plaintiff fails to limit the Requests to a specific time period.

**SPECIFIC OBJECTIONS TO PLAINTIFF'S DEFINITIONS, INSTRUCTIONS, AND RULES OF CONSTRUCTION**

1. Defendants object to the "Instructions," "Definitions," and "Rules of Construction" accompanying the Requests to the extent they purport to impose any obligation on Defendants different from or greater than those imposed by the Nevada Rules of Civil Procedure.

2. Defendants object to the "Instructions," "Definitions," and "Rules of Construction" to the extent they purport to require the production of Protected Health Information or other confidential or proprietary information without confidentiality protections sufficient to protect such information from disclosure, such as those found in the Confidentiality and Protective Order entered on June 24, 2020.

3. Defendants object to the definition of "Claim" or "Claims" as vague, not described with reasonable particularity, overbroad, unduly burdensome, not relevant to the claims or defenses in this case, and not proportional to the needs of this case to the extent they (1) include claims not specifically identified by Plaintiff in FESM000011, or (2) relate to claims, patients, or health benefits plans for which Defendants are not responsible for the at-issue claims administration.

4. Defendants object to the definition of "Data iSight" as vague, not described with reasonable particularity, overbroad, unduly burdensome, not relevant to the claims or defenses in this case, and not proportional to the needs of this case. Defendants contend that Plaintiff does not fully or accurately describe Data iSight, which is a service offered by MultiPlan, Inc. that provides pricing information concerning medical claims.

5. Defendants object to the definition of "Document," "Communication," and "Communicate" to the extent those terms include within their scope materials, at to the Requests, to the extent they seek documents or information protected by the attorney-client privilege, the attorney work product doctrine, the settlement privilege, or any other applicable privilege, including, but not limited to: information that was prepared for, or in anticipation of, litigation; that contains or reflects the analysis, mental impressions, or work of counsel; that



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contains or reflects attorney-client communications; or that is otherwise privileged.

6. Defendants object to the definition of the terms "Defendants," as used in the context of the Requests, and "You," and/or "Your" as vague, not described with reasonable particularity, overbroad, unduly burdensome, not proportional to the needs of the case, and seeking information that is not relevant to the outcome of any claims or defenses in this litigation. Plaintiff's definition includes, for example, "predecessors-in-interest," "partners," "any past or present agents," and "every person acting or purporting to act, or who has ever acted or purported to act, on their behalf," which suggests that Plaintiff seeks materials beyond Defendants' possession, custody, or control. Defendants will not search for or produce materials beyond their possession, custody, or control. Defendants have answered the Requests on behalf of Defendants, *as defined herein*, only based upon Defendants' knowledge, materials and information in Defendants' possession, and belief formed after reasonable inquiry.

7. Defendants object to the definition of "Fremont" as vague, not described with reasonable particularity, overbroad, unduly burdensome, not proportional to the needs of the case, and seeking information that is not relevant to the outcome of any claims or defenses in this litigation Plaintiff's definition includes, for example, "any past or present agents," "representatives," " partners," "predecessors-in-interest," "affiliates," and "every person acting or purporting to act, or who has ever acted or purported to act, on [its] behalf' without identifying these entities or persons with reasonable particularity, and creating an undue burden by requiring Defendants to identify them. In responding to the Requests, Defendants will construe "Fremont" to refer to those parties who were known to have been affiliated with Fremont Emergency Services (Mandavia), Ltd. during the Relevant Period.

8. Defendants object to the definition of "Emergency Services and Care," "Emergency Medicine Services," and "Emergency Department Services" as vague, not described with reasonable particularity, overbroad, unduly burdensome, not relevant to the claims or defenses in this case, and not proportional to the needs of this case to the extent they (1) include any medical services not related to the at-issue claims, or (2) relate to any medical

services for claims, patients, or health benefits plans for which Defendants are not responsible for the at-issue claims administration.

9. Defendants object to the definition of "Nonemergency Services and Care" as vague, not described with reasonable particularity, overbroad, unduly burdensome, not relevant to the claims or defenses in this case, and not proportional to the needs of this case to the extent it (1) includes services by not related to the at-issue claims, or (2) relates to the services for claims, patients, or health benefits plans for which Defendants are not responsible for the at-issue claims administration.

10. Defendants object to the definition of "Non-Participating Provider," "Non-Network Provider," "Participating Provider," and "Network Provider" as vague, not described with reasonable particularity, overbroad, unduly burdensome, not relevant to the claims or defenses in this case, and not proportional to the needs of this case to the extent they (1) include persons or entities that are not parties to this case, or (2) concern persons or entities unrelated to the at-issue claims.

11. Defendants object to the definition of "Plans" and "Plan Members" as vague, not described with reasonable particularity, overbroad, unduly burdensome, not relevant to the claims or defenses in this case, and not proportional to the needs of this case to the extent they (1) include health benefits plans and members of such plans not specifically identified by Plaintiff, (2) include health benefits plans that are not related to the at-issue claims, or (3) are referring to health benefits plans for which Defendants are not responsible for the at-issue claims administration.

12. Defendants object to the definition of "Provider" as vague, not described with reasonable particularity, overbroad, unduly burdensome, not relevant to the claims or defenses in this case, and not proportional to the needs of this case to the extent it (1) includes persons or entities that are not parties to this case, or (2) concern persons or entities unrelated to the at-issue claims.

13. Defendants object to Instruction No. 1 as vague and not described with reasonable particularity, as it uses the term Defendant, in the singular, without defining which of the

Defendants it is referring to. Defendants also object to Instruction No. 1 to the extent it seeks to impose obligations and/or penalties on Defendants beyond what is contemplated by the Nevada Rules of Civil Procedure or applicable local rules.

14. Defendants object to Instruction Nos. 2, 3, 4, 5, 6, 7, and 8 to the extent they seek to impose obligations and/or penalties on Defendants beyond what is contemplated by the Nevada Rules of Civil Procedure.

15. Defendants object to Instruction No. 9 as unduly burdensome and not proportional to the needs of the case insofar as it asks Defendants to provide "[for each document produced, identify the specific document request number or numbers to which the document is responsive." Defendants also object to Instruction No. 9 to the extent it seeks to impose obligations and/or penalties on Defendants beyond what is contemplated by the Nevada Rules of Civil Procedure.

16. Defendants object to Instruction Nos. 10, 11, and 12 to the extent they seek to impose obligations and/or penalties on Defendants beyond what is contemplated by the Nevada Rules of Civil Procedure.

17. Defendants object to Instruction No. 13 as unduly burdensome and not proportional to the needs of the case insofar as it asks Defendants to provide the name of "the person you believe to have possession of the missing documents, and the facts upon which you base your response." Defendants also object to Instruction No. 13 to the extent it seeks to impose obligations and/or penalties on Defendants beyond what is contemplated by the Nevada Rules of Civil Procedure.

**RESPONSES TO REQUESTS FOR PRODUCTION OF DOCUMENTS**

**REQUEST FOR PRODUCTION NO. 19:**

All documents regarding the Provider charges and/or reimbursement rates that You have paid to Participating or Non-Participating Providers from July 1, 2017, to the present in Nevada. Without waiving any right to seek further categories of documentation, at this juncture, Fremont is willing to accept, in lieu of contractual documents, data which is blinded or redacted and/or aggregated or summarized form.







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**RESPONSE:**

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that, even with the limitation proposed by Fremont, this Request is overbroad, unduly burdensome and seeks irrelevant information that is not proportional to the needs of the case. It is unclear what the relevance is of documents showing what the amounts Defendants paid to providers other than Fremont. Depending on, for example, the provider, the claim at issue, and/or the applicable health benefits plan documents, Defendants use different methodologies to calculate the allowed amount of reimbursement. The documents sought in this Request are therefore not relevant to determining the usual and customary rate of reimbursement for the claims Fremont is asserting in this litigation.

To the extent this Request is also seeking documents related to the reimbursement rates for claims of Fremont as a Non-Participating Provider, Defendants object to this Request on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 claims where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the documents relating to the reimbursement rates on those claims, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as Exhibit 1, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Responding further, subject to and without waiving Defendants' objections: please see document produced concurrently herewith as DEF010558.

Responding further, subject to and without waiving Defendants' objections: please see documents produced concurrently herewith as DEF011274–DEF011275.

Responding further, subject to and without waiving Defendants' objections: please see documents produced concurrently herewith as DEF045751–DEF045755.

**Responding further, subject to and without waiving Defendants' objections: please**

**see documents produced concurrently herewith as DEF045756–DEF045766. Defendants have made diligent efforts to respond to this Request, but reserve the right to supplement their response and objections.**

**REQUEST FOR PRODUCTION NO. 33:**

Produce any and all Documents and/or Communications regarding Your reimbursement rates paid or to be paid to out-of-network Emergency Medicine Groups and/or Complaints about Your level of payment for Emergency Medicine Services and/or Emergency Department Services received from out-of-network providers.

**RESPONSE:**

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request is overbroad, unduly burdensome and seeks information that is not relevant to Plaintiff's claims and not proportional to the needs of the case. This Request seeks a substantial amount of information regarding Defendants' rates of reimbursement to numerous non-parties which has no relevance to Plaintiff's claims. Defendants further object that this Request is overbroad since it is not limited to any specific time period. The term "Complaints" is also vague and overbroad, as noted in Defendants' objections to Plaintiff's Definitions. Indeed, as written, this Request appears to call for Defendants to produce any communication from any out of network provider to Defendants where the provider complains in any way about payment, regardless of when that communication was sent. There are likely hundreds of thousands if not millions of documents that could be responsive to this Request.

Defendants also object that this Request improperly asks that they reveal information about their agreements with other providers. Defendants' agreements with other providers typically contain confidentiality clauses such that producing these agreements could force Defendants to breach their obligations to these third parties. Moreover, the information sought is proprietary and subject to protection as a trade secret pursuant to NRS 600A.030(5) as this

information has independent value due to, among other things, the fact that it is not known to other providers like Fremont.

Responding further, subject to and without waiving Defendants' objections: please see document produced concurrently herewith as DEF010558.

Responding further, subject to and without waiving Defendants' objections: please see documents produced concurrently herewith as DEF011211, and DEF011274–DEF011275.

Responding further, subject to and without waiving Defendants' objections: please see documents produced concurrently herewith as DEF030301–DEF030406, and DEF030407–DEF030457.

Responding further, subject to and without waiving Defendants' objections: please see documents produced concurrently herewith as DEF045751–DEF045755.

**Responding further, subject to and without waiving Defendants' objections: please see documents produced concurrently herewith as DEF045756–DEF045766. Defendants have made diligent efforts to respond to this Request, but reserve the right to supplement their response and objections.**

Dated this 20th day of November, 2020.

*/s/ Brittany M. Llewellyn*

D. Lee Roberts, Jr., Esq.
Colby L. Balkenbush, Esq.
Brittany M. Llewellyn, Esq.
WEINBERG, WHEELER, HUDGINS, GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
Telephone: (702) 938-3838
Facsimile: (702) 938-3864
*Attorneys for Defendants*



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WEINBERG WHEELER HUDGINS GUNN & DIAL 003171

**CERTIFICATE OF SERVICE**

I hereby certify that on the 20th day of November, 2020, a true and correct copy of the foregoing **DEFENDANTS' THIRTEENTH SUPPLEMENTAL RESPONSES TO FREMONT EMERGENCY SERVICES (MANDAVIA) LTD.'S FIRST SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS** was electronically 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
*Attorneys for Plaintiffs*

*/s/ Audra R. Bonney*
An employee of WEINBERG, WHEELER, HUDGINS GUNN & DIAL, LLC

# EXHIBIT 15

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EXHIBIT 15

IN THE CIRCUIT COURT FOR THE THIRTEENTH JUDICIAL CIRCUIT
IN AND FOR HILLSBOROUGH COUNTY, FLORIDA

CASE NO: 17-CA-011207

GULF-TO-BAY ANESTHESIOLOGY
ASSOCIATES, LLC,

*Plaintiff,*

v.

UNITEDHEALTHCARE OF FLORIDA, INC.,
and UNITEDHEALTHCARE INSURANCE CO.,

*Defendants.*
_____/

**AMENDED COMPLAINT**



Plaintiff, Gulf-to-Bay Anesthesiology Associates, LLC ("GTB" or "Plaintiff"), by and through undersigned counsel, hereby sues Defendants UnitedHealthcare of Florida, Inc. and UnitedHealthcare Insurance Company (collectively, "United" or "Defendants"), and alleges as follows:

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**INTRODUCTION**

1. This lawsuit arises from United's failure to correctly pay GTB for medically necessary professional anesthesia health care services provided to the residents of Tampa and surrounding communities. More specifically, as of October 2017, United has underpaid GTB for more than 1700 instances in which GTB has provided anesthesia care to United's Members[1] since May 21, 2017 for a total underpaid amount that exceeds $1.5 million, which amounts and

[1] As used herein, the term "Members" means persons covered under health plans that are issued, operated or administered by either Defendant.



Lash&Goldberg LLP
LASHGOLDBERG.COM
MIAMI 100 Southeast 2nd Street, Suite 1200 • Miami, Florida 33131-2158 • 305 347 4040 tel 305 347 4050 fax
FT. LAUDERDALE 2500 Weston Road, Suite 220 • Weston, Florida 33331-3615 • 954 384 2500 tel 954 384 2510 fax
TAMPA 142 West Platt Street, Suite 118 • Tampa, FL 33606-2315 • 813-284-4002 tel

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encounters continue to accrue.[2] By filing this lawsuit, GTB seeks the recovery of the amount underpaid for each instance of care, plus interest thereon at a rate of 12% per annum under Florida's prompt pay statutes, Fla. Stat. §§ 627.6131(7), 641.3155(6). GTB also requests an order from the Court declaring the rate at which Florida law requires United to pay GTB for its anesthesia services, and a mandatory injunction compelling United to pay GTB at such rates for the out-of-network anesthesiology services Plaintiff renders to United's Members in the future.

**PARTIES**

2. Plaintiff Gulf-to-Bay Anesthesiology Associates, LLC is a limited liability company formed under the laws of Delaware. GTB's principal place of business is located in Hillsborough County, Florida. At all relevant times to the allegations stated herein, GTB has provided professional anesthesia services in Hillsborough County, Florida and the surrounding area.

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3. Upon information and belief, Defendant UnitedHealthcare of Florida, Inc. ("United HMO") is a Florida for-profit corporation with its principal place of business in Hillsborough County, Florida. United HMO operates under a certificate of authority issued by the Florida Office of Insurance Regulation as a health maintenance organization ("HMO") in Florida under Fla. Stat. § 641.17, *et seq.*

4. Upon information and belief, Defendant UnitedHealthcare Insurance Company ("United PPO") is a foreign for-profit corporation with its principal place of business in Hartford, Connecticut. As a preferred provider organization, United PPO operates under a certificate of

[2] This lawsuit and the claims asserted herein do not relate to or involve GTB's right to payment, but rather the applicable rate of payment GTB is entitled to receive for its services. This action does not include any claims in which benefits were denied nor does it challenge any coverage determinations under any health plan that may be subject to the Employee Retirement Income Security Act of 1974.





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authority issued by the Florida Office of Insurance Regulation as a life and health insurer in Florida under Fla. Stat. § 624.01, *et seq.*

5. Upon information and belief, Defendants United PPO and United HMO are affiliated corporate entities and have made centralized decisions regarding the payment of the claims at issue herein. Thus, this action involves common issues of law and fact such that joinder of the claims against United PPO and United HMO in this action will further judicial efficiency and economy and will tend to avoid unnecessary costs or delay.

**JURISDICTION AND VENUE**

6. This Court has jurisdiction pursuant to Fla. Stat. § 26.012(2) because this dispute involves an amount in controversy in excess of $15,000. Plaintiff has claims against United PPO for more than $15,000. Plaintiff has claims against United HMO for more than $15,000.

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7. Defendants are engaged in substantial activity within Florida and maintain offices in Florida.

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8. Pursuant to Fla. Stat. § 47.051, venue is proper in Hillsborough County because United HMO, a Florida corporation, has, and usually keeps, an office for transaction of its customary business in Hillsborough County. Pursuant to Fla. Stat. § 47.051, venue is proper in Hillsborough County because United PPO, a foreign corporation doing business in Florida, has agents and other representatives located in Hillsborough County. In addition, Plaintiff resides in Hillsborough County and its causes of action against United HMO and United PPO have accrued, in whole or in part, in Hillsborough County.





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## FACTS

***Relationship Between Plaintiff and United***

9. GTB began in 1994 as a private practice group of anesthesiologists dedicated to providing high-quality patient-focused anesthesia health care services. Today, GTB employs more than 50 board certified anesthesiologists and more than 100 certified registered nurse anesthetists who provide anesthesia care for all surgical and pain management services at Tampa General Hospital and thirteen other locations in the area. GTB's anesthesiology professionals render anesthesia services to patients, including United Members, in the medical facilities in which they are staffed.

10. United is one of the country's largest health benefit insurers and claims administrators. In exchange for premiums, United pays for health care services rendered to Members of United's commercial health care products and platforms, including prepaid health care plans such as HMOs and traditional insurance products such as indemnity plans and PPO products.[3] United also provides claims processing services, including making the determination of whether a claim should be paid and paying the claim, for employer self-funded plans.

11. Beginning on or around May 20, 2003 and continuing until May 20, 2017, GTB and United were parties to a participation agreement ("Participation Agreement"). Pursuant to the Participation Agreement, GTB agreed to provide anesthesia services to United's Members, and United agreed to pay GTB for such services at a discounted rate from GTB's charges.[4] For the

[3] United also sells products related to government-sponsored programs, such as Medicare Advantage and managed Medicaid. Those products are not at issue in this litigation, which arises only from claims involving Defendants' commercial plans and products.

[4] Pursuant to Section 10.9 of the Participation Agreement, the reimbursement rates are confidential and therefore not specifically identified herein.



Lash&Goldberg LLP
LASHGOLDBERG.COM
MIAMI 100 Southeast 2nd Street, Suite 1200 • Miami, Florida 33131-2158 • 305 347 4040 tel 305 347 4050 fax
FT. LAUDERDALE 2500 Weston Road, Suite 220 • Weston, Florida 33331-3615 • 954 384 2500 tel 954 384 2510 fax
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duration of the period during which the Participation Agreement remained in effect, GTB was a participating provider in United's provider network.

12. Under the Participation Agreement, GTB agreed to accept payment from United at a rate that was less than its charges in exchange for the benefits associated with being a participating provider in United's provider network.

***Plaintiff Becomes an Out-of-Network Provider***

13. On May 21, 2017, the Participation Agreement terminated, and Plaintiff thereupon became an out-of-network provider.

14. GTB and United have not renewed, reinstated, or otherwise replaced the Participation Agreement between them. Since May 21, 2017, GTB has not been a party to a contract with United that governs the reimbursement, or any other aspect, of the services provided by GTB to United's Members. Plaintiff has thus been an "out-of-network" provider with respect to United since May 21, 2017.

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15. Despite its out-of-network status, GTB has continued to provide medically necessary, covered anesthesia health care services to United's Members following the termination of the Participation Agreement in May 2017.

16. Since the termination of the Participation Agreement, GTB has not agreed to accept any form of discounted rate from United or to be bound by United's payment policies or rate schedules with respect to any of the health care services provided by GTB to United's Members. Notwithstanding the absence of any such agreement, United has consistently and unilaterally applied an unlawful discount to its payments to GTB for GTB's anesthesia services.

17. United has consistently paid for GTB's anesthesia services rendered to United's Members from May 21, 2017 through the present, but at rates less than GTB is entitled to receive





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by law. United has made unlawful discounted payments to GTB for the services GTB has rendered to United's Members since May 21, 2017. As of October 2017, GTB has been underpaid by more than $1.5 million on more than 1700 patient encounters, which amounts and encounters continue to accrue.

18. Indeed, even though GTB is an out-of-network provider, and therefore has not agreed to accept discounted reimbursement rates from United, United has reimbursed GTB for the services GTB rendered to United's Members on or after May 21, 2017, at rates that are substantially *less* than the discounted rate Plaintiff had previously agreed to accept from United under the Participation Agreement. As an out-of-network provider, GTB has not received the benefits associated with being a participating provider in United's provider network in exchange for which GTB had previously agreed to accept discounted reimbursement rates.

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***United's Failure to Reimburse Plaintiff in Accordance with Florida Law***

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19. Fla. Stat. § 641.513(5), which is part of Florida's HMO Act, provides that reimbursement for emergency services by providers such as GTB "who do[] not have a contract with the [HMO] shall be the lesser of: (a) The provider's charges; (b) The usual and customary provider charges for similar services in the community where the services were provided; or (c) The charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim."

20. Florida law requires that insurers reimburse out-of-network health care providers, such as GTB, for both the non-emergency and emergency services that such providers render to the insurer's members in accordance with the provisions of Fla. Stat. § 641.513(5). *See* Fla. Stat. § 627.64194(4) ("An insurer must reimburse a nonparticipating provider of services under subsections (2) and (3) as specified in s. 641.513(5), reduced only by insured cost share





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responsibilities as specified in the health insurance policy, within the applicable timeframe provided in s. 627.6131.").[5]

21. GTB has not reached agreement with United regarding any charges within sixty days of the submittal of the claims at issue in this action.

22. For the claims at issue in this action, United has underpaid GTB by reimbursing GTB substantially less than GTB's charges and the "usual and customary provider charges for similar services in the community where the services were provided."

23. On average, United has reimbursed GTB for the claims at issue in this action at approximately half of GTB's charges for the services rendered.

24. With full knowledge of its obligations to appropriately reimburse GTB, United authorized or approved GTB's rendering of anesthesiology services to United's Members.

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25. United is aware that GTB provided anesthesiology services to United's Members with the reasonable expectation and understanding that GTB's services had been approved by United and that GTB would be appropriately reimbursed by United.

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26. With full knowledge of its obligations under Florida law described above, United has continued to authorize its Members to receive anesthesiology services from GTB at hospitals and other medical facilities in Hillsborough County and elsewhere throughout central Florida.

27. United's authorization of such services and its acknowledgement of its responsibility for payment is further confirmed by the fact that it has regularly and consistently

[5] *See also* Fla. Stat. § 627.64194(2) (providing that "[a]n insurer is solely liable for payment of fees to a nonparticipating provider of covered emergency services provided to an insured in accordance with the coverage terms of the health insurance policy"); Fla. Stat. § 627.64194(3) (providing that "[a]n insurer is solely liable for payment of fees to a nonparticipating provider of covered nonemergency services provided to an insured in accordance with the coverage terms of the health insurance policy").





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issued payment on GTB's claims for those services at all material times, albeit at rates less than what GTB is owed.

28. United's refusal to appropriately pay GTB for the anesthesiology services GTB has provided to United's Members has caused, and continues to cause, GTB to suffer damages, which are ongoing in nature.

29. GTB is entitled to interest at a rate of 12% per annum on the amounts overdue on the underpaid claims. *See* Fla. Stat. §§ 627.6131(7), 641.3155(6).

30. All conditions precedent to the institution and maintenance of this action have been performed, waived, or otherwise satisfied.

**COUNT I – Violation of Florida Statute § 627.64194 (United PPO)**

31. GTB incorporates herein the allegations of paragraphs 1-30 above.

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32. From May 21, 2017 to present, GTB and United PPO have not had a written contract between them governing the rates at which United PPO must reimburse GTB for its anesthesiology services.

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33. From May 21, 2017 to present, GTB has not been a participating provider in United PPO's network; GTB has been an out-of-network provider since May 21, 2017.

34. From May 21, 2017 to present, GTB has rendered both emergent and non-emergent anesthesiology services to United PPO's Members who were covered under an individual or group health insurance policy issued by United PPO and delivered or issued for delivery in the state of Florida. All such services have been medically necessary, covered services.

35. Fla. Stat. § 627.64194(4) requires that all insurers, such as United PPO, reimburse nonparticipating providers, such as GTB, for both non-emergency services and emergency services





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rendered to the insurer's members according to the methodology set forth in Fla. Stat. § 641.513(5).

36. Pursuant to Fla. Stat. § 641.513(5), nonparticipating providers are entitled to reimbursement for services rendered in an amount equal to the lesser of the provider's charges, the "usual and customary provider charges for similar services in the community where the services were provided," or "[t]he charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim."

37. GTB has not reached agreement with United PPO regarding any charges within sixty days of the submittal of the claims at issue in this action. Therefore, GTB is entitled to reimbursement from United PPO at the lesser of its charges or (if hypothetically different) the "usual and customary provider charges for similar services in the community where the services were provided."

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38. United PPO has reimbursed GTB for the anesthesiology services it has rendered from May 21, 2017 to present at substantially less than GTB's charges.

39. United PPO has reimbursed GTB for the anesthesiology services it has rendered from May 21, 2017 to present at substantially less than the usual and customary provider charges for similar services in the community where GTB rendered such services to United PPO's Members.

40. Accordingly, United PPO has failed to reimburse GTB in accordance with Fla. Stat. § 641.513(5) for both the non-emergent and emergent anesthesiology services GTB rendered to United PPO's Members who were covered under an individual or group health insurance policy issued by United PPO and delivered or issued for delivery in the state of Florida, and United PPO has therefore violated Fla. Stat. § 627.64194(4).





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**COUNT II – Violation of Florida Statute § 641.513 (United HMO)**

41. GTB incorporates herein the allegations of paragraphs 1-30 above.

42. From May 21, 2017 to present, GTB and United HMO have not had a written contract between them governing the rates at which United HMO must reimburse GTB for its anesthesiology services.

43. From May 21, 2017 to present, GTB has not been a participating provider in United HMO's network; GTB has been an out-of-network provider since May 21, 2017.

44. From May 21, 2017 to present, GTB has rendered emergency anesthesiology services to United HMO's Members. All such services have been covered services.

45. Fla. Stat. § 641.513(5) provides that all HMOs, such as United HMO, must reimburse non-participating providers for emergent health care services in an amount equal to the lesser of the provider's charges, the "usual and customary provider charges for similar services in the community where the services were provided," or "[t]he charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim."

46. GTB has not reached agreement with United HMO regarding any charges within sixty days of the submittal of the claims at issue in this action. Therefore, GTB is entitled to reimbursement at the lesser of its charges or (if hypothetically different) the "usual and customary provider charges for similar services in the community where the services were provided."

47. United HMO has reimbursed GTB for the emergent anesthesiology services it has rendered to United HMO's Members from May 21, 2017 to present at substantially less than GTB's charges.

48. United HMO has reimbursed GTB for the emergent anesthesiology services it has rendered to United HMO's Members from May 21, 2017 to present at substantially less than the

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usual and customary provider charges for similar services in the community where GTB rendered such services to United HMO's Members.

49. Accordingly, United HMO has failed to reimburse GTB for the emergency anesthesiology services GTB rendered to United HMO's Members in accordance with Fla. Stat. § 641.513(5). United HMO has therefore violated Fla. Stat. § 641.513(5).

**COUNT III – Breach of Contract Implied-in-Fact (United PPO and United HMO)**

50. GTB incorporates herein the allegations of Paragraphs 1-30 above.

51. In addition, and/or in the alternative, from May 21, 2017 to present, GTB and United have not had a written contract between them governing the rates at which United must reimburse GTB for its anesthesiology services.

52. From May 21, 2017 to present, GTB has not been a participating provider in United's network; GTB has been an out-of-network provider since May 21, 2017.

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53. From May 21, 2017 to present, United knew that GTB would provide anesthesiology services to United's Members at all medical facilities at which GTB's anesthesiology professionals are staffed in connection with any surgeries and procedures for which anesthesiology services would be required.

54. From May 21, 2017 to present, United pre-authorized United's Members to have nonemergency surgeries and procedures for which they knew that anesthesiology services would be required and that GTB would provide such anesthesiology services.

55. From May 21, 2017 to present, GTB has rendered both emergent and non-emergent anesthesiology services to United's Members.

56. From May 21, 2017 to present, United has been aware that GTB was entitled to and expected to be paid the fair value of the anesthesiology services it rendered to United's Members.





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57. From May 21, 2017 to present, GTB understood that United intended to reimburse GTB the fair value of the anesthesiology services GTB rendered to United's Members.

58. From May 21, 2017 to present, United has consistently and regularly approved GTB to provide anesthesiology services in the treatment of United's Members and impliedly agreed to pay GTB the fair value of its services by pre-authorizing various medical facilities and/or surgeons to perform surgeries or procedures, knowing that GTB would be performing anesthesiology services in connection therewith.

59. From May 21, 2017 to present, United has further acknowledged its responsibility for payment and approval of GTB's rendering of anesthesiology services in the treatment of United's Members by regularly and consistently paying GTB for such services, although at rates lower than what GTB is owed.

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60. From May 21, 2017 to present, United has further acknowledged its responsibility for payment and approval of the claims at issue in this action, as all such claims have been processed and adjudicated by United and determined by United to be covered services.

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61. From May 21, 2017 to present, United has breached its implied-in-fact contract with GTB by reimbursing GTB for the claims at issue at less than the fair value of the services provided.

62. At all material times, all necessary conditions precedent for United to perform its obligation to reimburse GTB for the services GTB rendered pursuant to United's implied-in-fact contract with GTB were met, satisfied, and/or waived.

63. United's breach of its implied-in-fact contract with GTB has caused GTB damage in an amount to be determined at trial equal to the difference between the fair value of the services





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provided by GTB and the amounts paid by Defendants to GTB for the anesthesiology services GTB's professionals have rendered to United's Members on and after May 21, 2017.

**COUNT IV – Quantum Meruit (United PPO and United HMO)**

64. GTB incorporates herein the allegations of Paragraphs 1-30 above.

65. In addition, and/or in the alternative, from May 21, 2017, GTB has conferred a direct benefit upon United by, among other things, authorizing and/or approving GTB to provide valuable professional anesthesiology services to United's Members, but then failing to properly reimburse GTB for those authorized or approved services. The direct benefit GTB provided to United is further evidenced by United's prior contractual relationship with GTB.

66. Between May 20, 2003 and May 20, 2017, United and GTB were parties to a Participation Agreement in which GTB agreed to provide anesthesia services to United's Members. In exchange, United agreed to pay GTB for anesthesia services at a discounted rate from GTB's usual and customary charges. During the time in which the Participation Agreement was in full force and effect, United routinely acknowledged that it would be paying GTB for these services by providing GTB with authorization and/or approval for these services.

67. Subsequent to the termination of the Participation Agreement on May 20, 2017, United continued to authorize and/or approve GTB to provide medically necessary services to United's Members. In doing so, United continued to obtain this direct previously contracted-for benefit of the Participation Agreement (i.e., anesthesiology services provided to United's Members), but failed to pay GTB the appropriate rate of payment for those same services.

68. In exchange for premiums, United owes United's Members an obligation to pay for the covered medical services they receive. United derives a direct benefit from GTB's provision of professional anesthesiology services to United's Members because it is through GTB's



Lash&Goldberg LLP
LASHGOLDBERG.COM
MIAMI 100 Southeast 2nd Street, Suite 1200 • Miami, Florida 33131-2158 • 305 347 4040 tel 305 347 4050 fax
FT. LAUDERDALE 2500 Weston Road, Suite 220 • Weston, Florida 33331-3615 • 954 384 2500 tel 954 384 2510 fax
TAMPA 142 West Platt Street, Suite 118 • Tampa, FL 33606-2315 • 813-284-4002 tel

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provision of those services that United fulfills its obligations to its Members. Thus, GTB's services allow United to discharge its contractual obligation to its Members.

69. There is no dispute that the anesthesiology services at issue that GTB provided to United's Members were covered services, because United adjudicated them, determined they were covered services, and paid GTB for them, except at an amount less than the fair value of the services. When GTB provides covered anesthesiology services to United's Members, United receives the benefit of having its contractual obligations to its Members discharged.

70. United has knowledge of the benefits GTB conferred on United by providing anesthesiology services to United's Members because, *inter alia*, United received, processed, and adjudicated GTB's claims for such services and determined that they were covered services under United's contracts with its Members.

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71. United has voluntarily accepted and retained the benefits GTB conferred on United by providing anesthesiology services to United's Members because, *inter alia*, United adjudicated GTB's claims for such services and determined that they were covered services under United's contracts with its Members.

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72. Moreover, for the non-emergent anesthesiology services GTB rendered to United's Members, United pre-authorized its Members' surgeries or other procedures with the knowledge that GTB would be providing anesthesiology services to United's Members in connection with the approved procedure and that GTB expected to be reimbursed at the fair value for its services.

73. United voluntarily accepted, retained and enjoyed, and continues to accept, retain, and enjoy, the benefits conferred upon it by GTB, knowing that GTB expected and expects to be paid the fair value for its services. However, United has failed to reimburse GTB the fair value of the services GTB has rendered to United's Members since May 21, 2017.





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74. Under the present circumstances, it would be extraordinarily inequitable for United to fail to reimburse GTB the fair value of the anesthesiology services it rendered to United's Members, while retaining the benefits GTB conferred upon United.

75. Florida law affords non-contracted providers, like GTB, with a cause of action for quantum meruit against payers, like United, in circumstances such as these, when the non-contracted provider discharges the payer's obligations to its Members to pay for covered services, but fails to adequately compensate the non-contracted providers. *See Merkle v. Health Options, Inc.*, 940 So. 2d 1190, 1199 (Fla. 4th DCA 2006) (holding that the trial court erred in dismissing a claim for unjust enrichment where a provider alleged that an insurer benefitted from medical services provided to patient insureds); *Shands Teaching Hosp. and Clinics, Inc. v. Beech Street Corp.*, 899 So. 2d 1222, 1227-28 (Fla. 1st DCA 2005).

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76. Accordingly, United is liable in *quantum meruit* to GTB for failing to reimburse GTB the fair value of the services GTB rendered to United's Members and owes as damages the difference between the fair value of the services GTB rendered to United's Members and the amounts United has paid for those services.

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**COUNT V – Unjust Enrichment (United PPO and United HMO)**

77. GTB incorporates herein the allegations of Paragraphs 1-30 above.

78. In addition, and/or in the alternative, from May 21, 2017, GTB has conferred a direct benefit upon United by, among other things, authorizing and/or approving GTB to provide valuable professional anesthesiology services to United's Members, but then failing to properly reimburse GTB for those authorized or approved services. The direct benefit GTB provided to United is further evidenced by United's prior contractual relationship with GTB.



Lash&Goldberg LLP
LASHGOLDBERG.COM
MIAMI 100 Southeast 2nd Street, Suite 1200 • Miami, Florida 33131-2158 • 305 347 4040 tel 305 347 4050 fax
FT. LAUDERDALE 2500 Weston Road, Suite 220 • Weston, Florida 33331-3615 • 954 384 2500 tel 954 384 2510 fax
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79. Between May 20, 2003 and May 20, 2017, United and GTB were parties to a Participation Agreement in which GTB agreed to provide anesthesia services to United's Members. In exchange, United agreed to pay GTB for anesthesia services at a discounted rate from GTB's usual and customary charges. During the time in which the Participation Agreement was in full force and effect, United routinely acknowledged that it would be paying GTB for these services by providing GTB with authorization and/or approval for these services.

80. Subsequent to the termination of the Participation Agreement on May 20, 2017, United continued to authorize and/or approve GTB to provide medically necessary services to United's Members. In doing so, United continued to obtain this direct previously-contracted-for benefit of the Participation Agreement (i.e., anesthesiology services provided to United's Members), but failed to pay GTB the appropriate rate of payment for those same services.

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81. In exchange for premiums, United owes United's Members an obligation to pay for the covered medical services they receive. United derives a direct benefit from GTB's provision of anesthesiology services to United's Members because it is through GTB's provision of those services that United fulfills its obligations to its Members. Thus, GTB's services allowed United to discharge its contractual obligation to its Members.

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82. There is no dispute that the anesthesiology services at issue that GTB provided to United's Members were covered services, because United adjudicated them, determined they were covered services, and paid GTB for them, except at an amount less than the fair value of the services. When GTB provides covered anesthesiology services to United's Members, United receives the benefit of having its contractual obligations to its Members discharged.

83. United has knowledge of the benefits GTB conferred on United by providing anesthesiology services to United's Members because, *inter alia*, United received, processed, and





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adjudicated GTB's claims for such services and determined that they were covered services under United's contracts with its Members.

84. United has voluntarily accepted and retained the benefits GTB conferred on United by providing anesthesiology services to United's Members because, *inter alia*, United adjudicated GTB's claims for such services and determined that they were covered services under United's contracts with its Members.

85. Moreover, for the non-emergent anesthesiology services GTB rendered to United's Members, United pre-authorized its Members' surgeries or other procedures with the knowledge that GTB would be providing anesthesiology services to United's Members in connection with the approved procedure and that GTB expected to be reimbursed at the fair value for its services.

86. United voluntarily accepted, retained and enjoyed, and continues to accept, retain, and enjoy, the benefits conferred upon it by GTB, knowing that GTB expected and expects to be paid the fair value for its services. However, United has failed to reimburse GTB the fair value of the services GTB has rendered to United's Members since May 21, 2017.

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87. Under the present circumstances, it would be extraordinarily inequitable for United to fail to reimburse GTB the fair value of the anesthesiology services it rendered to United's Members, while retaining the benefits GTB conferred upon United.

88. Florida law affords non-contracted providers, like GTB, with a cause of action for unjust enrichment against payers, like United, in circumstances such as these, when the non-contracted provider discharges the payer's obligations to its Members to pay for covered services, but fails to adequately compensate the non-contracted providers. *See Merkle v. Health Options, Inc.*, 940 So. 2d 1190, 1199 (Fla. 4th DCA 2006) (holding that the trial court erred in dismissing a claim for unjust enrichment where a provider alleged that an insurer benefitted from medical



Lash&Goldberg LLP
LASHGOLDBERG.COM
MIAMI 100 Southeast 2nd Street, Suite 1200 • Miami, Florida 33131-2158 • 305 347 4040 tel 305 347 4050 fax
FT. LAUDERDALE 2500 Weston Road, Suite 220 • Weston, Florida 33331-3615 • 954 384 2500 tel 954 384 2510 fax
TAMPA 142 West Platt Street, Suite 118 • Tampa, FL 33606-2315 • 813-284-4002 tel

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services provided to patient insureds); *Shands Teaching Hosp. and Clinics, Inc. v. Beech Street Corp.*, 899 So. 2d 1222, 1227-28 (Fla. 1st DCA 2005).

89. Accordingly, United has been unjustly enriched by failing to reimburse GTB at the fair value of the services GTB rendered to United's Members and owes as damages the difference between the fair value of the services GTB rendered to United's Members and the amounts United has paid for those services.

**COUNT VI – Declaratory Judgment (United PPO and United HMO)**

90. GTB incorporates herein the allegations of Paragraphs 1-30 above.

91. United PPO has reimbursed GTB for the anesthesiology services it has rendered on and after May 21, 2017 at substantially less than GTB's charges and the usual and customary provider charges for similar services in the community where GTB rendered such services to United PPO's Members. Accordingly, United PPO has failed to reimburse GTB in accordance with Fla. Stat. § 641.513(5) for both the non-emergent and emergent anesthesiology services GTB rendered to United PPO's Members, and United PPO has therefore violated Fla. Stat. § 627.64194(4). United PPO continues to reimburse GTB for both emergency and non-emergency anesthesiology services rendered to United PPO's Members at substantially less than GTB's charges and the usual and customary provider charges for similar services in the community where GTB rendered such services to United PPO's Members. United PPO has indicated that it intends to continue to reimburse GTB for anesthesiology services in such an unlawful manner.

92. United HMO has reimbursed GTB for the emergent anesthesiology services it has rendered to United HMO's Members on and after May 21, 2017 at substantially less than GTB's charges and the usual and customary provider charges for similar services in the community where GTB rendered such services to United HMO's Members. Accordingly, United HMO has failed to

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reimburse GTB for the emergency anesthesiology services GTB rendered to United HMO's Members in accordance with Fla. Stat. § 641.513(5). United HMO has therefore violated Fla. Stat. § 641.513(5). United HMO continues to reimburse GTB for emergency anesthesiology services rendered to United HMO's Members at substantially less than GTB's charges and the usual and customary provider charges for similar services in the community where GTB rendered such services to United HMO's Members. United HMO has indicated that it intends to continue to reimburse GTB for emergency anesthesiology services in such an unlawful manner.

93. United has reimbursed GTB for the emergent anesthesiology services it has rendered to United HMO's Members from May 21, 2017 to present at substantially less than the fair value of GTB's services.

94. United continues to reimburse GTB for the emergent and non-emergent anesthesiology services it renders to United's Members at substantially less than the fair value of GTB's services.

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95. GTB and United intend for GTB to continue to provide anesthesiology services to United's Members as an out-of-network provider.

96. Based on the foregoing allegations, real and substantial justiciable controversies exist between United PPO and GTB concerning whether the rates at which United PPO reimburses GTB for emergency and non-emergency anesthesiology services rendered to United PPO's Members violate Fla. Stat. § 627.64194(4).

97. Based on the foregoing allegations, real and substantial justiciable controversies exist between United HMO and GTB concerning whether the rates at which United HMO reimburses GTB for emergency anesthesiology services rendered to United PPO's Members violate Fla. Stat. § 641.513(5).





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98. Based on the foregoing allegations, real and substantial justiciable controversies exist between United and GTB concerning the rates of reimbursement to which GTB is entitled as an out-of-network provider of emergency and non-emergency anesthesiology services to United's Members under the Florida common law doctrines of breach of implied-in-fact contract, *quantum meruit*, and unjust enrichment.

99. These are actual, definite, concrete and substantial controversies that require an immediate determination of GTB's rights of reimbursement and whether the rates of reimbursement that United has paid to GTB comply with Florida law.

100. Declaratory relief is appropriate here because such judgment will serve a useful purpose in clarifying and settling the rates of reimbursement to which GTB is entitled from United for the anesthesiology services GTB renders to United's Members for so long as GTB remains an out-of-network provider.

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101. There is a bona fide, actual, present practical need for a declaration. Declaratory relief will terminate and afford relief from uncertainty, insecurity, and controversy concerning the rates at which United must reimburse GTB for the anesthesiology services GTB continues to render to United's Members as an out-of-network provider.

102. All antagonistic and adverse interests relating to the declaration sought herein are parties to this action.

103. The relief sought is not merely to seek legal advice of the Court nor does GTB seek answers to questions propounded from mere curiosity.

104. GTB is consequently entitled to a declaration of its rights pursuant to Section 86.021, Florida Statutes.

**PRAYER FOR RELIEF**

WHEREFORE, GTB prays that this Court:





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(i) enter judgment against Defendants and in GTB's favor, awarding GTB compensatory damages for the anesthesiology services GTB's professionals have rendered to United's Members from May 21, 2017 through the date of judgment;

(ii) award GTB prejudgment and postjudgment interest at a rate of 12% per annum on the amounts overdue on the underpaid claims;

(iii) award GTB its costs;

(iv) enter an order declaring the rate(s) at which United must reimburse GTB for the anesthesiology services GTB renders to United's Members as an out-of-network provider;

(v) issue a mandatory injunction compelling United to reimburse GTB no less than the reimbursement rates to which the Court declares GTB is entitled from United for the anesthesiology services GTB renders to United's Members as an out-of-network provider; and

(vi) grant GTB any and all further relief as the Court deems just and appropriate under the circumstances.

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**JURY DEMAND**

Plaintiff hereby demands a trial by jury for all claims so triable.



Lash&Goldberg LLP
LASHGOLDBERG.COM
MIAMI 100 Southeast 2nd Street, Suite 1200 • Miami, Florida 33131-2158 • 305 347 4040 tel 305 347 4050 fax
FT. LAUDERDALE 2500 Weston Road, Suite 220 • Weston, Florida 33331-3615 • 954 384 2500 tel 954 384 2510 fax
TAMPA 142 West Platt Street, Suite 118 • Tampa, FL 33606-2315 • 813-284-4002 tel

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Respectfully Submitted:

**LASH & GOLDBERG LLP**
142 West Platt Street, Suite 118
Tampa, FL 33606-2315
Miami, Florida 33131
Tel: 813-284-4002 / Fax: 305-347-4050
*Counsel for Plaintiff Gulf-to-Bay Anesthesiology Associates, LLC*

By: */s/ Alan D. Lash*
**ALAN D. LASH**
Florida Bar No. 510904
alash@lashgoldberg.com
**JUSTIN C. FINEBERG**
Florida Bar No. 0053716
jfineberg@lashgoldberg.com
**JONATHAN E. FEUER**
Florida Bar No. 0068752
mehren@lashgoldberg.com
**NICHOLAS A. ORTIZ**
Florida Bar No. 117381
nortiz@lashgoldberg.com

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Dated: February 12, 2019

**CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that a true and correct copy of the foregoing document was served on February 12, 2019, via the Florida Courts E-Filing Portal upon counsel of record identified on the below Service List.

By: */s/ Alan D. Lash*
**ALAN D. LASH**





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**SERVICE LIST**

DANIEL ALTER, ESQ.
Dan.alter@gray-robinson.com
SHAYNA A. FREYMAN, ESQ.
Shayna.freyman@gray-robinson.com
GRAY ROBINSON, P.A.
401 East Las Olas Boulevard, Suite 1000
Fort Lauderdale, FL 33301
Telephone: (954) 761-8111

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# EXHIBIT 16

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EXHIBIT 16

**IN THE CIRCUIT COURT FOR THE THIRTEENTH JUDICIAL CIRCUIT IN AND FOR HILLSBOROUGH COUNTY, FLORIDA**

GULF-TO-BAY ANESTHESIOLOGY ASSOCIATES, LLC,

CASE NO.: 17-CA-011207

*Plaintiff,*

v.

UNITEDHEALTHCARE OF FLORIDA, INC., and UNITEDHEALTHCARE INSURANCE CO.,

*The Insurance Companies.*
_____/

**ORDER DENYING DEFENDANTS' MOTION TO COMPEL DISCOVERY REGARDING PLAINTIFF'S INTERNAL COST STRUCTURE**

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THIS MATTER came before the Court on September 24, 2020, on UnitedHealthcare of Florida, Inc. and UnitedHealthcare Insurance Co.'s (collectively, "Defendants") Motion to Compel Plaintiff's Supplemental Responses to Defendants' First Request for Production filed August 21, 2020 ("Defendants' RFP Motion") and Motion to Compel Plaintiff's Supplemental Responses to Defendants' First Set of Interrogatories filed August 25, 2020, (collectively "Defendants' Discovery Motions"). This Order addresses Requests for Production Numbers 2-7, 29-30, 55, 62-64 and Interrogatory Numbers 19 and 30, which seek production of documents and information from Plaintiff, Gulf to Bay Anesthesiology Associates, LLC ("Plaintiff"), relating to Plaintiff's internal cost structure ("Cost Discovery"). The Court having reviewed Defendants' Discovery Motions, Plaintiff's Omnibus Response to Defendants' Motions filed September 14, 2020 ("Omnibus Response"), having heard argument of counsel, having reviewed the Court file, and being otherwise fully advised in the premises, hereby ORDERS AND ADJUDGES as follows:

1. This case involves Plaintiff's claims for damages for medical services provided to Defendants' commercial members. Plaintiff alleges that since May 2017, there has been no written

agreement between the parties that dictates the amount Defendants should pay for these medical services, and Plaintiff alleges that Defendants have reimbursed Plaintiff at below fair market rates (the "Disputed Commercial Claims"). In the Amended Complaint, Plaintiff alleges six causes of action, as follows: (1) violation of section 627.64194, Florida Statutes, which sets forth the rates at which preferred provider organizations (PPOs) must reimburse out-of-network healthcare providers (Count I); (2) violation of section 641.513, Florida Statutes, which sets forth the rates at which health maintenance organizations (HMOs) must reimburse out-of-network healthcare providers (Count II); (3) breach of contract implied-in-fact (Count III); (4) quantum meruit (Count IV); (5) unjust enrichment (Count V); and (6) declaratory relief (Count VI).

2. Defendants answered the Amended Complaint on February 22, 2019. Defendants did not raise any affirmative defenses challenging the reasonableness of Plaintiff's rates, charges, or pricing. Additionally, Defendants did not assert any counterclaims that would otherwise expand the issues as framed by the Amended Complaint.

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3. The relevant framework for analyzing the appropriate reimbursement of the Disputed Commercial Claims arises out of sections 641.513(5)[1] for HMOs and 627.64194(4) for PPOs (which incorporates section 641.513(5) to the analysis of both emergent and non-emergent services). This framework provides as follows:

> (5) Reimbursement for services pursuant to this section by a provider who does not have a contract with the health maintenance organization shall be the lesser of:

[1] While section 641.513 expressly applies to emergency services, Rule 69O-191.049, Florida Administrative Code, extends the obligation of an HMO to pay hospital-based providers, including anesthesiologists, for "medically necessary and approved physician care rendered to a non-Medicare subscriber at a contracted hospital." Moreover, section 641.3154 obligates HMOs to pay providers, such as Healthcare Provider, for authorized services without regard to the location where the medical services were rendered. As alleged in the Amended Complaint, the Disputed Claims were all authorized and determined by Defendants to be medically necessary.



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(a) The provider's charges;
(b) The usual and customary provider charges for similar services in the community where the services were provided; or
(c) The charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim.

4. Notably, the statute focuses on "charges." There is no provision of this statute that identifies the provider's "costs" as a relevant consideration in the analysis.

5. The leading case interpreting section 641.513(5) is *Baker Cty. Medical Svcs., Inc. v. Aetna Health Mgmt., LLC*, 31 So. 3d 842, 845-46 (Fla. 1st DCA 2010). In that case, the First District analyzed the wording of the statute and the relevant provisions and concluded:

> The term "charges" is not defined in section 641.513(5). When a statute does not define a term, we rely on the dictionary to determine the definition. *See Green v. State*, 604 So.2d 471, 473 (Fla.1992). "Charge" is defined as a "[p]rice, cost, or expense." BLACK'S LAW DICTIONARY 248 (8th ed. 2004). In paragraph (5)(a), the term "charge" is modified by the terms "usual" and "customary." "Usual" is defined as "[o]rdinary; customary" and "[e]xpected based on previous experience." *Id.* at 1579. "Customary" is defined as "[a] record of all of the established legal and quasi-legal practices in a community." *Id.* at 413. **In the context of the statute, it is clear what is called for is the fair market value of the services provided. Fair market value is the price that a willing buyer will pay and a willing seller will accept in an arm's-length transaction.** *See United States v. Cartwright*, 411 U.S. 546, 551, 93 S.Ct. 1713, 36 L.Ed.2d 528 (1973).

*Id.* at 845 (emphasis added).

6. The *Baker County* Court then concluded that in determining the fair market value of the services, it is appropriate to consider the amounts billed and the amounts accepted by providers, except for patients covered by Medicare and Medicaid. *Id.* at 845-46. Consistent with the plain language of section 641.513(5), the First District did not mention or reference "costs" as having any relevance or impact on the analysis of the statute or the determination of "fair market value." *Id.*



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7. The Defendants' Discovery Motions seek to compel Cost Discovery, arguing that such discovery is relevant to the reasonableness of Plaintiff's charge. Defendants rely on *Giacalone v. Helen Ellis Mem'l Hosp. Found*., 8 So. 3d 1233 (Fla. 2d DCA 2009) in support of its position[2]. In opposition, Plaintiff argues that Cost Discovery is irrelevant and not likely to lead to the discovery of admissible evidence based on the applicable statutes and case law related specifically to the claims and defenses asserted in this case. Plaintiff further contends that *Giacolone* is distinguishable, because the legal claims and issues in that case are materially different from those asserted here.

8. After careful consideration, the Court finds that the Cost Discovery is irrelevant and not likely to lead to the discovery of admissible evidence under Rule 1.280, Fla.R.Civ.P.[3] The legal theories asserted by Plaintiff and at issue in this case involve the determination of the lesser of its charges or the "usual and customary provider charges for similar services in the community where the services were provided." There is no mention of "costs" in the applicable statutes as a relevant factor in the analysis. And, the reasonableness of its charges is measured against the

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[2] Defendants also rely on a news article in *Pro Publica* purporting to review a case and case materials pending in a court in Texas, that were subsequently sealed. Defendants have not identified the specific legal claims and defenses in the Texas case, how any issues in that case relate to the specific issues in this case or why this Court should rely on third-hand discussions in a news article to inform this Court on how to address the specific issues under Florida law. Accordingly, the Court does not consider this article as probative or informative for purposes of ruling on the pending Motions.

[3] Under Rule 1.280, Fla.R.Civ.P., a party may obtain discovery regarding any non-privileged matter that is relevant to any party's claim or defense and/or likely to lead to the discovery of admissible evidence. *See, e.g., Allstate Ins. Co. v. Langston*, 655 So. 2d 91, 94 (Fla. 1995). While the scope of discovery is broad, it is not unlimited. For example, discovery is not intended to be a "fishing expedition," and courts routinely foreclose a party's attempt to use discovery in that manner. *See, e.g., Walter v. Page*, 638 So. 2d 1030, 1031-32 (Fla. 2nd DCA 1994); *see also State Farm Mut. Auto. Ins. Co. v. Parrish*, 800 So. 2d 706, 707 (Fla. 5th DCA 2001); *Sugarmill Woods Civic Ass'n v. Southern States Utilities*, 687 So. 2d. 1346, 1351 (Fla. 1st DCA 1997). Put simply, a litigant is not entitled "carte blanche to irrelevant discovery." *Langston*, 655 So. 2d at 95.



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"usual and customary provider charges for similar services in the community." The statute does not expressly contemplate any analysis of provider costs, either of the Plaintiff or of other providers in the community, and the Court refuses to read such a provision into the statute.

9. Likewise, the *Baker County* Court also determined that the relevant inquiry was in the "fair market value" of the services provided, defined as "the price that a willing buyer will pay and a willing seller will accept in an arm's length transaction." *Baker County*, 31 So. 3d at 845. As explained by the First District, that analysis focuses solely the price of the services, rather than the costs of the services. Importantly, the First District did not identify costs as a factor in the analysis or having any relevance to this determination.

10. Additionally, the Florida Standard Jury Instructions provide that the determination of damages for breach of implied-in-fact contract, *quantum meruit*, and unjust enrichment is based upon the fair compensation for the services rendered and/or benefit conferred – not the costs to provide the service. *See* Florida Standard Jury Instructions in Contract and Business Cases, § 416.7, Restatement (First) of Restitution § 1 cmt. b (1937). Plaintiff's internal cost structure is therefore irrelevant to the analysis of the value of the services conferred by the Plaintiff or the factors to be considered by the jury.

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11. The Court has carefully considered Defendants' arguments and reliance on *Giacalone;* however, *Giacolone* is distinguishable. *Giacalone* involved a contract dispute between an uninsured patient and a hospital regarding the patient's agreement to pay for services in accordance with "the regular rates and terms of the hospital." *Id.* at 1234. The hospital sued to collect its full billed charges, claiming those charges reflected the "reasonable value" of the services. The defendant/patient asserted defenses of unconscionability (unreasonable pricing), and asserted counterclaims for unfair or deceptive trade practices. *Id.* The Second DCA characterized



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the defendant's "primary claim" as the charges were unreasonable. There were no claims asserted under section 641.513 or 627.64194, Florida Statutes, and *Giacolone* did not discuss those statutes or *Baker County*.

12. At issue before the Second DCA in *Giacolone* was the trial court's form order issuing a blanket denial and containing no explanation of its decision to deny discovery regarding the hospital's charges and discounts provided to various categories of patients (including Medicare and Medicaid),[4] and the hospital's internal cost structure. *Id.* at 1235. The Second DCA did not find specifically that internal cost discovery was relevant or discoverable, but remanded the case back to the trial court for specific consideration of the individual requests in the context of the claims asserted by an uninsured patient against a hospital for breach of contract. *Id.* at 1236.

13. By contrast, Defendants have not raised any unreasonable pricing claims here, either by affirmative defense or counterclaim. Instead, the pleadings here focus on a statutory analysis that addresses the fair market value of the services provided, determined by the price a willing buyer would pay and willing seller would accept. *Baker County*, 31 So. 3d at 845-846. The focus of that analysis is on market pricing.[5] The Court has carefully considered the Cost Discovery requests in the context of this case, and finds that *Giacolone* is not controlling regarding discovery here.

14. Finally, the Court notes that the parties have already exchanged discovery contemplated by *Baker County*, including, for example, (a) information regarding Plaintiff's

[4] As noted above, the *Baker County* Court held that payments from Medicare and Medicaid were not relevant to the determination under section 641.513, Florida Statutes.

[5] Notably, Defendants have not explained how discovery of Plaintiff's internal cost structure would be relevant to a market rate analysis, how Defendants would compare Plaintiff's internal cost structure to the internal cost structure of others in the market, or how Defendants would even obtain that cost information from non-parties.



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charges; (b) amounts accepted by Plaintiff for similar services by other commercial insurers; and (c) amounts paid by Defendants for commercial insurance products for similar services in the community. This is precisely the information that is discoverable and is to be weighed by the jury in determining the fair market value of Plaintiff's anesthesia services. In contrast, Plaintiff's internal cost structure is wholly irrelevant and not likely to lead to the discovery of admissible evidence.

Based on the foregoing, it is hereupon **ORDERED** and **ADJUDGED** that Defendants' Motions to obtain documents and information regarding Plaintiff's internal costs and discovery requests related thereto are **DENIED**.[6]

**DONE and ORDERED** this ___ day of _____ 2020, in Tampa, Hillsborough County, Florida.

Electronically Conformed 12/1/2020
Christopher Sabella

**CIRCUIT COURT JUDGE**

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Copies furnished to:
Counsel of Record

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[6] This Order also applies to any third party discovery issued by the Defendants, including but not limited to Defendants' Notice of Intent to Serve *Subpoena Duces Tecum* Without Deposition Pursuant to Rule 1.351, Fla.R.Civ.P. for Production of Documents from Non-Party TeamHealth Holdings, Inc. and Notice of Intent to Serve *Subpoena Duces Tecum* Without Deposition Pursuant to Rule 1.351, Fla.R.Civ.P. for Production of Documents from Non-Party Collect RX, Inc.



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# EXHIBIT 17



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EXHIBIT 17

IN THE CIRCUIT COURT FOR THE
17TH JUDICIAL CIRCUIT IN AND FOR
BROWARD COUNTY, FLORIDA

CASE NO: CACE19-013026 (07)
JUDGE: JACK TUTER

FLORIDA EMERGENCY PHYSICIANS
KANG & ASSOCIATES, M.D., INC., et al.,

Plaintiffs,

vs.

SUNSHINE STATE HEALTH PLAN, INC., et al.,

Defendants.
_____/

**ORDER ON DEFENDANTS' FIRST MOTION TO COMPEL PRODUCTION**



THIS CAUSE came before the Court on Defendants' First Motion to Compel Production. The Court, having reviewed the motion and the responses, having heard argument of counsel, and being otherwise duly advised in the premises, rules as follows:



This action arises out of the alleged failure by Defendants to pay Plaintiffs for certain emergency medicine services provided by Plaintiffs to patients covered under the commercial healthcare plans underwritten and administered by the Defendants. On February 12, 2020, Plaintiffs, Florida Emergency Physicians Kang & Associates, M.D., Inc.; InPhyNet Contracting Services, LLC; InPhyNet South Broward, LLC; Paragon Contracting Services, LLC; Paragon Emergency Services, LLC; and Southwest Florida Emergency Management, Inc. (collectively "Plaintiffs") filed their Amended Complaint against Defendants, Sunshine State Health Plan, Inc.; Celtic Insurance Company; and Centene Management Company, LLC (collectively "Defendants"), alleging the following causes of action: (1) violation of section 641.513, Florida Statutes (count I); (2) breach of implied-in-fact contract (count II); (3) breach of implied-in-law contract (count III); (4) unjust enrichment (count IV); and (5) declaratory relief (count V).

On September 28, 2020, Defendants filed the instant First Motion to Compel Production (the "Motion to Compel"). In their motion, Defendants seek to compel the production of: (1) Plaintiffs' claims data reflecting Plaintiffs' reimbursements for emergency services from Medicaid Managed Care and Medicare Advantage plans; (2) Plaintiffs' claims data reflecting Plaintiffs' reimbursements for emergency services from traditional fee-for-service Medicaid and Medicare; and (3) documents discussing or analyzing Plaintiffs' cost of care. On October 16, 2020, Plaintiffs filed their Response in Opposition. On October 19, 2020, Defendants filed a Reply in Support of the Motion to Compel. A hearing on the Motion to Compel was held before this Court on October 21, 2020. The parties filed their respective supplemental briefings as requested by the Court on October 28, 2020.

This action is premised on Plaintiffs' allegation that Defendants violated section 641.513(5), Florida Statutes, by reimbursing the claims at issue at substantially less than the statutorily-required amount. *See* Am. Comp. at ¶¶ 1 and 2. In the instant motion, Defendants seek the production of Plaintiffs' claims data for emergency services from Medicare Advantage, Medicaid Managed Care, and traditional fee-for-service Medicare and Medicaid. However, after careful review of the Amended Complaint, the claims at issue are solely comprised of **commercial, non-governmental claims** and do not include any governmental-sponsored products such as Medicare Advantage, Medicaid Managed Care or traditional Medicare or Medicaid. *See* Am. Comp. at ¶ 1. Accordingly, the Court finds Defendants' discovery requests regarding Plaintiffs' claims data for Medicare and Medicaid-based programs and traditional fee-for-service Medicare and Medicaid irrelevant.

The Court also finds Defendants' discovery requests regarding Medicare and Medicaid-based claims reimbursement data not likely to lead to admissible evidence. As recognized in *Baker County Medical Services, Inc. v. Aetna Health Management, LLC*, 31 So. 3d 842, 844 (Fla. 1st DCA 2010), "[r]imbursement to hospitals providing emergency medical services to patients who subscribe

to an HMO that does not have a contract with the hospital is determined according to section 641.513(5), Florida Statutes." Section 641.513(5), states:

> Reimbursement for services pursuant to this section by a provider who does not have a contract with the health maintenance organization shall be the lesser of:
>
> (a) The provider's charges;
>
> (b) The usual and customary provider charges for similar services in the community where the services were provided; or
>
> (c) The charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim.

§ 641.513(5), Fla. Stat. In their Amended Complaint, Plaintiffs assert that for the non-participating claims, Defendants have underpaid Plaintiffs by reimbursing Plaintiffs substantially less than Plaintiffs' charges and the "usual and customary provider charges for similar services in the community where the services were provided." *See* Am. Comp. at ¶ 41.



The court in *Baker* interpreted the term "usual and customary provider charges" under section 641.513(5) to mean the "fair market value" of the services provided which it defined to be "the price that a willing buyer will pay and a willing seller will accept in an arm's-length transaction." *Baker,* 31 So. 3d at 845. The *Baker* court further held that "[i]n determining the fair market value of the services, it is appropriate to consider the amounts billed and the amounts accepted by providers with one exception. The reimbursement rates for Medicare and Medicaid are set by government agencies and cannot be said to be 'arm's-length.'" *Id*. at 845-46. "Moreover, in the emergency medical services context, hospitals do not have the option that private providers have to refuse to provide services to Medicare or Medicaid patients. Thus, it is not appropriate to consider the amounts accepted by providers for patients covered by Medicare and Medicaid." *Id*. at 846. As determined in *Baker,* the amounts billed and accepted to emergency services providers for Medicare and Medicaid based products are not to be considered by the fact finder in determining the fair market value of services under section 641.513(5). Accordingly, and based on the foregoing,

Plaintiffs' objections are hereby **SUSTAINED** and the Motion to Compel is hereby **DENIED** with respect to Defendants' requests for production of Medicare and Medicaid based claims reimbursement data.

Defendants also seek the production of documents discussing or analyzing Plaintiffs' cost of care. This concerns Defendants' Requests for Production No. 32-34.

> Request for Production #32: Documents sufficient to show Plaintiffs' costs of providing care for the claims identified in response to Request No. 1.
>
> Request for Production #33: All documents reflecting, discussing, or identifying the factors Plaintiffs consider when calculating the costs of providing care or services for health care claims, including the claims identified in response to Request No. 1.
>
> Request for Production #34: All documents analyzing or comparing Plaintiffs' costs of providing care to the amount of Plaintiffs' billed charges and/or amounts paid by any payor.

Defendants maintain that Plaintiffs' costs of care is relevant as it has a bearing on the determination of the "fair value" of the services. Plaintiffs objected to the above requests for production mainly on relevance and burden grounds. However, in their responses to Requests of Production No. 33 and 34, Plaintiffs also raised objections on the grounds of attorney-client privilege and/or work product doctrine.



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In opposition to the instant motion, Plaintiffs maintain that cost of care is irrelevant and not discoverable in this case. Plaintiffs rely on *Baker* in support of their position. In *Baker*, the First District identified two types of information that is relevant to determining the usual and customary provider charges: (1) the amounts billed/charged, and (2) the amounts accepted, by emergency services providers for commercial claims in the relevant community where the services were provided. Plaintiffs therefore contend that since the determination does not involve any analysis or consideration of an emergency service provider's underlying costs of providing these services and thus any information regarding such costs, the information is irrelevant and not properly discoverable in this case.

Following the hearing on the instant motion, on December 4, 2020, Plaintiffs filed a Notice of Supplemental Authority, attaching an "Order Denying Defendants' Motion to Compel Discovery Regarding Plaintiff's Internal Cost Structure" issued by the Thirteenth Judicial Circuit in and for Hillsborough County, Florida, in case styled *Gulf-to-Bay Anesthesiology Associates, LLC v. Unitedhealthcare of Florida, Inc., et al*., Case No.: 17-CA-011207. In *Gulf-to-Bay*, in denying the motion to compel, the court recognized that section 641.513(5) does not expressly contemplate any analysis for provider costs and that as set forth in *Baker*, the focus should remain on the price of the services, rather than the costs of the services. Stated differently, it is Plaintiffs' position that because neither the statute nor *Baker* identify costs as a factor in the analysis or having any relevance to the determination, providers' costs are irrelevant and not discoverable. However, this Court is not persuaded. As pointed out in Defendants' response, while the *Baker* court held that it was "appropriate to consider…amounts billed and the amounts accepted by providers," the court did not say it was inappropriate to allow discovery into other areas. *Baker*, 31 So. 3d at 845. In sum, the Court finds that *Baker* does not preclude the compelling of the cost of care discovery.

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Furthermore, in *Gulf-to-Bay*, the court found *Giacalone v. Helen Ellis Memorial Hospital Foundation, Inc.*, 8 So. 3d 1232 (Fla. 2d DCA 2009) distinguishable based in part on the fact that the defendant/patient in *Giacalone* had asserted defenses of unconscionability (unreasonable pricing). The court in *Gulf-to-Bay* determined where defendants did not raise any unreasonable pricing claims, either by affirmative defense or counterclaim, the pleadings were focused solely on a statutory analysis that addresses the fair market value of the services provided. However, after review, this Court finds *Gulf-to-Bay* distinguishable. Here, Defendants have raised at least four affirmative defenses relating to the reasonableness of Plaintiffs' charges and pricing.

Moreover, while this Court is mindful that the cases cited by Defendants in support of their position are not directly on point, *i.e.*, involve an out-of-network emergency service provider's

claims against health insurers under section 641.513(5), the Court nonetheless finds that Defendants are entitled to the requested discovery. The cases cited by Defendants found cost of care discovery relevant to analyze the reasonableness and fairness of rates. *See Colomar v. Mercy Hospital, Inc*., 461 F. Supp. 2d 1265, 1272 (S.D. Fla. 2006); *Giacalone v. Helen Ellis Memorial Hospital Foundation, Inc.*, 8 So. 3d 1232 (Fla. 2d DCA 2009); *Gulfcoast Surgery Center, Inc. v. Fisher*, 107 So. 3d 493 (Fla. 2d DCA 2013); *Lawton-Davis v. State Farm Mutual Automobile Insurance Company*, 2016 WL 1383015 (M.D. Fla. Apr. 7, 2016). Further, Plaintiffs have not provided this Court with any other authority in support of their position apart from *Baker* and the non-binding decision of *Gulf-to-Bay*. Accordingly, and based on the foregoing, Plaintiffs' objections are hereby **OVERRULED** and the Motion to Compel is hereby **GRANTED** with respect to Defendants' requests for production of documents discussing or analyzing Plaintiffs' cost of care. This ruling does not apply to any documents which Plaintiffs allege to be protected by the attorney-client privilege and/or work product doctrine. Upon review, should Plaintiffs determine a privilege applies than Plaintiffs shall file a privilege log noting the withheld document and the relevant privilege.



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Accordingly, it is hereby:

**ORDERED** that Defendants' First Motion to Compel Production is hereby **DENIED IN PART AND GRANTED IN PART** for the reasons stated above. Plaintiffs shall provide documents responsive to Requests 32-34, regarding Plaintiffs' costs of emergency services within forty-five (45) days from the date of this Order.

**DONE AND ORDERED** in Chambers, Fort Lauderdale, Florida, this 21st day of December, 2020.

/s/ *Jack Tuter*
JACK TUTER
CIRCUIT JUDGE

Copies Furnished to:
Alan D Lash, Address : alash@lashgoldberg.com
Alan D Lash, Address : lashgoldberg@gmail.com
Alan D Lash, Address : yyzquierdo@lashgoldberg.com
Baxter D. Drennon, Address : bdrennon@wlj.com
Christopher Flynn, Address : cflynn@crowell.com
Collin Kennedy, Address : cdk@hanshawkennedy.com
Collin Kennedy, Address : mrw@hanshawkennedy.com
Daniel Alter, Address : amy.miguelez@gray-robinson.com
Daniel Alter, Address : dan.alter@gray-robinson.com
G. Meredith Parnell, Address : mparnell@crowell.com
Joshua Harris, Address : jharris@azalaw.com
Judy Simmons Henry, Address : jhenry@wlj.com
Justin C. Fineberg, Address : yyzquierdo@lashgoldberg.com
Justin C. Fineberg, Address : jfineberg@lashgoldberg.com
Kevin Leyendecker, Address : kleyendecker@AZALAW.COM
Michael A. Thompson, Address : mthompson@wlj.com
Michael Killingsworth, Address : sliuskos@azalaw.com
Michael Killingsworth, Address : mkillingsworth@azalaw.com
Michael Killingsworth, Address : lpeter@azalaw.com
Michael L Ehren, Address : kevans@lashgoldberg.com
Michael L Ehren, Address : lashgoldberg@gmail.com
Michael L Ehren, Address : mehren@lashgoldberg.com
Michael L. Ehren, Address : kevans@lashgoldberg.com
Michael L. Ehren, Address : mehren@lashgoldberg.com
Michael W. Lieberman, Address : cpulliam@crowell.com
Michael W. Lieberman, Address : rrosenberg@crowell.com
Michael W. Lieberman, Address : mlieberman@crowell.com
Patrick Kevin Leyendecker, Address : etattegrain@azalaw.com
Patrick Kevin Leyendecker, Address : lpeter@azalaw.com
Patrick Kevin Leyendecker, Address : kleyendecker@azalaw.com
Rochelle-Leigh Rosenberg, Address : rrosenberg@crowell.com

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# EXHIBIT 18

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EXHIBIT 18

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Steven D. Grierson
CLERK OF THE COURT

**ANSC**
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*
WEINBERG, WHEELER, HUDGINS,
GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
Telephone: (702) 938-3838
Facsimile: (702) 938-3864

*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,

vs.

UNITEDHEALTH GROUP, INC., a Delaware corporation; 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; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20,

Defendants.

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

**DEFENDANTS' ANSWER TO PLAINTIFFS' FIRST AMENDED COMPLAINT**



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270. Answering paragraph 270 of the First Amended Complaint, United denies the allegations contained in this paragraph.

271. Answering paragraph 271 of the First Amended Complaint, United admits that it processes and, where appropriate, pays claims for services provided to participants in health plans it insures or administers. United denies the remaining allegations in Paragraph 271.

272. Answering paragraph 272 of the First Amended Complaint, United denies the allegations contained in this paragraph.

273. Answering paragraph 273 of the First Amended Complaint, United denies the allegations contained in this paragraph.

274. Responding to Plaintiff's **"REQUEST FOR RELIEF"**, including the "WHEREFORE" statement and all subparts thereto, Defendants deny that they are liable to Plaintiffs in any fashion or in any amount.



**AFFIRMATIVE DEFENSES**

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Defendants have not yet completed their investigation in this matter. Notably, Plaintiffs have failed to adequately plead the specific claims at issue, including as to individual members, the health care coverage they possessed on the dates of service at issue, the terms of their various health care plans, the specific services rendered, and the payment and processing history to date. Without such basic identification, United is unable to adequately respond to the asserted claims. United reserves all rights to alter or amend its responsive pleading and affirmative defenses at such time as Plaintiffs provide the information necessary to identify the claims at issue.

Without assuming the burden of proof where it otherwise rests with Plaintiffs, United asserts the following defenses as may prove applicable after discovery or trial:

**FIRST AFFIRMATIVE DEFENSE**

For the reasons detailed in United's Motion to Dismiss, Plaintiffs' First Amended Complaint fails to state a claim upon which relief can be granted.

**SECOND AFFIRMATIVE DEFENSE**

To the extent to be determined through review of subsequently identified claims, some or all of the claims may be preempted by the Employee Retirement Income Security Act of 1974



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("ERISA") to the extent the members in question obtain their health care coverage through employer-based health plans. Such claims relate to payments under plans governed by ERISA, and all such claims are both conflict and completely preempted by ERISA for the reasons detailed in United's Motion to Dismiss.

**THIRD AFFIRMATIVE DEFENSE**

This Court does not have subject matter jurisdiction over the claims asserted against United. Plaintiffs' claims arise under ERISA and therefore implicate federal question jurisdiction.

**FOURTH AFFIRMATIVE DEFENSE**

The claims asserted are barred by the absence of an applicable duty running from United to Plaintiffs. Among other reasons, as out-of-network providers, Plaintiffs have chosen not to enter into any contractual relationship or rate agreement with United, nor has any duty arisen by operation of Nevada law for the reasons detailed in United's Motion to Dismiss.

**FIFTH AFFIRMATIVE DEFENSE**

The terms and conditions of the applicable health plans are incorporated by reference, as if fully set forth herein, and stand as a bar to some or all of the relief requested. United reserves all rights with respect to asserting this defense once Plaintiffs have adequately identified the specific benefit claims that they contend were underpaid for purposes of the lawsuit, and the specific plans at issue

**SIXTH AFFIRMATIVE DEFENSE**

Some or all of Plaintiffs' billed charges are excessive under the applicable standards, and/or Plaintiffs have failed to identify any basis for entitlement to demand receipt of any fixed percentage of billed charges.

**SEVENTH AFFIRMATIVE DEFENSE**

Some or all of the claims asserted are untimely, and/or subject to statute of limitations or contractual limitations periods. United reserves all rights with respect to asserting this defense once Plaintiffs have adequately identified the specific benefit claims that they contend were underpaid for purposes of the lawsuit, and the specific plans at issue.

**EIGHTH AFFIRMATIVE DEFENSE**

Some or all of the claims asserted are subject to rates set by Plaintiffs' participation in MultiPlan, Inc. United reserves all rights with respect to asserting this defense once Plaintiffs have adequately identified the specific benefit claims that they contend were underpaid for purposes of the lawsuit.

**NINTH AFFIRMATIVE DEFENSE**

To the extent that Plaintiffs have any right to receive plan benefits, that right is subject to basic preconditions and prerequisites that have not been established, such as that the patients are members of United on the date of service, that the coordination of benefits has been applied, that the services were medically necessary, that an emergency medical condition was present, that Plaintiffs timely submitted correctly coded claims and supplied any requested documentation, and/or that any necessary authorizations were obtained, and United reserves all rights with respect to asserting any and all such defenses once Plaintiffs have adequately identified the specific claims that they contend were underpaid for purposes of the lawsuit.

**TENTH AFFIRMATIVE DEFENSE**

Plaintiffs lack standing to pursue claims against United.

**ELEVENTH AFFIRMATIVE DEFENSE**

Upon information and belief, and to the extent to be determined through subsequent claims identification by Plaintiffs, some or all of the Defendants did not function as an insurer or issuer of the unspecified health plan coverage alleged to be at issue, and Plaintiffs therefore lack standing as to any such Defendant.

**TWELFTH AFFIRMATIVE DEFENSE**

Plaintiffs failed to timely correct known defects with respect to some or all of the claims asserted. United reserves all rights with respect to asserting this defense once Plaintiffs have adequately identified the specific benefit claims that they contend were underpaid for purposes of the lawsuit, and the specific plans at issue.

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**THIRTEENTH AFFIRMATIVE DEFENSE**

Plaintiffs' claims are barred, in whole or in part, to the extent that they seek to unjustly enrich Plaintiffs by allowing them to retain funds in excess of any amounts due for covered services under plans insured or administered by United. United reserves all rights with respect to asserting this defense once Plaintiffs have adequately identified the specific benefit claims that they contend were underpaid for purposes of the lawsuit, and the specific plans at issue.

**FOURTEENTH AFFIRMATIVE DEFENSE**

Plaintiffs' claims are barred, in whole or in part, to the extent they have not suffered any damages.

**FIFTEENTH AFFIRMATIVE DEFENSE**

Plaintiffs' claims are barred, in whole or in part, to the extent any alleged liability to or damages suffered by Plaintiffs were not proximately caused by United, or by the conduct alleged.

**SIXTEENTH AFFIRMATIVE DEFENSE**

Plaintiffs' claims are barred in whole or in part by the failure to exhaust mandatory administrative and/or contractual remedies. United reserves all rights with respect to asserting this defense once Plaintiffs have adequately identified the specific benefit claims that they contend were underpaid for purposes of the lawsuit, and the specific plans at issue.

**SEVENTEENTH AFFIRMATIVE DEFENSE**

Plaintiffs' claims are barred in whole or in part to the extent Plaintiffs are pursuing claims that they do not possess the legal right to pursue, including, but not limited to, benefit claims with respect to which they did not obtain effective assignments from their patients.

**EIGHTEENTH AFFIRMATIVE DEFENSE**

Plaintiffs' claims are barred, in whole or in part, to the extent that Plaintiffs have not mitigated their damages by seeking reimbursement from other sources, including, but not limited to, other health plans, programs, or entities that may have had an obligation to pay.

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**NINETEENTH AFFIRMATIVE DEFENSE**

Plaintiffs' claims are barred in whole or in part, by the equitable doctrines of waiver, estoppel, laches, and/or unclean hands. United reserves all rights with respect to asserting this defense once Plaintiffs have adequately identified the specific benefit claims that they contend were underpaid for purposes of the lawsuit, and the specific plans at issue.

**TWENTIETH AFFIRMATIVE DEFENSE**

Plaintiffs' claims are barred to the extent the monetary relief sought under theories of restitution, disgorgement, constructive trust and/or any other theory is not equitable, and thus not available under those theories.

**TWENTY-FIRST AFFIRMATIVE DEFENSE**

Plaintiffs' claims are barred, in whole or in part, to the extent Plaintiffs failed to sue the appropriate entity. United reserves all rights with respect to asserting this defense once Plaintiffs have adequately identified the specific benefit claims that they contend were underpaid for purposes of the lawsuit, and the specific plans at issue.

**TWENTY-SECOND AFFIRMATIVE DEFENSE**

Plaintiffs' claims are barred, in whole or in part, by the doctrines of accord and satisfaction and/or release. United reserves all rights with respect to asserting this defense once Plaintiffs have adequately identified the specific benefit claims that they contend were underpaid for purposes of the lawsuit, and the specific plans at issue.

**TWENTY-THIRD AFFIRMATIVE DEFENSE**

Plaintiffs' claims are barred, in whole or in part, by the doctrines of res judicata and/or collateral estoppel. United reserves all rights with respect to asserting this defense once Plaintiffs have adequately identified the specific benefit claims that they contend were underpaid for purposes of the lawsuit, and the specific plans at issue.

**TWENTY-FOURTH AFFIRMATIVE DEFENSE**

Plaintiffs' claims are subject to setoff and/or recoupment with respect to claims for which United made payment on the basis of current procedural terminology ("CPT") or other billing codes included in Plaintiffs' submissions that Plaintiffs' clinical records of their patients' care



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reveal to have been improperly submitted, either because Plaintiffs' clinical records do not support submission of the codes at all, or because Plaintiffs' clinical records establish that different codes should have been submitted.

**TWENTY-FIFTH AFFIRMATIVE DEFENSE**

Plaintiffs' claims are subject to setoff and/or recoupment with respect to claims for which United made payment on the basis of Plaintiffs' billed charges and those billed charges exceeded the billed charges submitted to other payors, where Plaintiffs never intended to collect such charges from any other payors, or where the charges were otherwise in error.

**TWENTY-SIXTH AFFIRMATIVE DEFENSE**

Plaintiffs are not entitled to relief because they have received all payments due, if any, for the covered services they provided in accordance with the terms of their patients' health plans.

**TWENTY-SEVENTH AFFIRMATIVE DEFENSE**

Plaintiffs' claim for punitive damages cannot be sustained because an award of punitive damages that is subject to no predetermined limit, such as a maximum multiple of compensatory damages or a maximum amount of punitive damages that may be imposed, would: (1) violate Defendants' Due Process rights guaranteed by the Fifth and Fourteenth Amendments to the United States Constitution; (2) violate Defendants' rights not to be subjected to an excessive award; and (3) be improper under the Constitution, common law and public policies of Nevada.

**TWENTY-EIGHTH AFFIRMATIVE DEFENSE**

It has been necessary for Defendants to employ the services of an attorney to defend the action and a reasonable sum should be allowed Defendants for attorney's fees and all incurred costs of the suit.

**TWENTY-NINTH AFFIRMATIVE DEFENSE**

Pursuant to NRCP 11, as amended, all possible affirmative defenses may not have been alleged herein insofar as facts were not available after reasonable inquiry upon the filing of this Answer, and therefore, Defendants reserve the right to amend their Answer to Plaintiffs' First Amended Complaint to allege additional affirmative defenses if subsequent investigation warrants.

WHEREFORE, having fully responded to the allegations of the First Amended Complaint, United prays:

1. That Plaintiffs' First Amended Complaint be dismissed with prejudice and that Plaintiffs take nothing thereby;

2. That Plaintiffs take nothing by their First Amended Complaint;

3. That Defendants be discharged from this action without liability;

4. That the Court award to Defendants all of their costs and attorneys' fees in defending this action; and

5. That the Court award to Defendants such other and further relief as the Court deems just and proper.

Dated this 8th day of July, 2020.

*/s/ Brittany M. Llewellyn*

D. Lee Roberts, Jr., Esq.
Colby L. Balkenbush, Esq.
Brittany M. Llewellyn, Esq.
WEINBERG, WHEELER, HUDGINS, GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
Telephone: (702) 938-3838
Facsimile: (702) 938-3864

*Attorneys for Defendants UnitedHealth Group, Inc., UnitedHealthcare Insurance Company, United HealthCare Services Inc., UMR, Inc., Oxford Health Plans, Inc., Sierra Health and Life Insurance Co., Inc., Sierra Health-Care Options, Inc., and Health Plan of Nevada, Inc.*

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**CERTIFICATE OF SERVICE**

I hereby certify that on the 8th day of July, 2020, a true and correct copy of the foregoing **DEFENDANTS' ANSWER TO PLAINTIFFS' FIRST AMENDED COMPLAINT** was electronically filed/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
*Attorneys for Plaintiffs*

*/s/ Kelly L. Pierce*
An employee of WEINBERG, WHEELER, HUDGINS GUNN & DIAL, LLC

# EXHIBIT 19



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EXHIBIT 19

# Surprise! Out-of-Network Billing for Emergency Care in the United States

March 2018

**Zack Cooper, Yale University**
**Fiona Scott Morton, Yale University and NBER**
**Nathan Shekita, Yale University**

**Abstract**: Hospitals and physicians independently negotiate contracts with insurers. As a result, a privately insured individual can attend an in-network hospital, but receive care from an out-of-network physician. Because patients do not choose their emergency physician, emergency physicians can remain out-of-network and charge high prices without losing volume. This strong outside option improves their bargaining power with insurers. We show that emergency physician outsourcing firms take advantage of this strong outside option by either remaining out-of-network or by using it to negotiate higher in-network rates. We propose a policy that would restore competition to the ED physician market and protect consumers.

Zack Cooper (zack.cooper@yale.edu)
Fiona Scott Morton (fiona.scottmorton@yale.edu)
Nathan Shekita (nathan.shekita@yale.edu)





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## 1. Introduction

Each year, there are 41.9 emergency department (ED) visits per 100 people in the United States (US) (Rui et al. 2013). When patients access EDs, they are consuming a package of care that includes hospital and physician services. However, what most privately insured patients do not realize is that hospitals and physicians independently negotiate contracts with insurers. While patients generally have a choice over which hospital they attend (only 14.5 percent of ED patients arrive via ambulance), once they enter a hospital ED, they have little or no discretion over the ED physician who treats them (Rui et al. 2013). As a result, it is possible for a patient to choose a hospital ED that is in-network with his insurer, but receive care and a subsequent bill from a physician working in that ED who is out-of-network with his insurer. When a physician is out-of-network, she bills for her "charges," which we show in our data are more than double the standard, in-network, payments made to most ED physicians. As we describe in this paper, a fundamental problem in emergency medicine in the US is that ED physicians face completely inelastic demand when they are practicing inside in-network hospital EDs. As a result, they need not set their prices in response to market forces. Ultimately, the practice of out-of-network billing from inside in-network hospitals undercuts the functioning of health care labor markets, exposes patients to significant financial risk, and reduces social welfare.

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The financial harm patients face if they are treated by an out-of-network physician can be substantial. In many instances, when a patient is treated by an out-of-network physician, insurers will only pay physicians a portion of their out-of-network charges. This leaves the physician to attempt to collect the difference between her charges and the insurer's payment (the balance) from the patient (so-called balanced or surprise billing). These balanced bills can be hundreds or thousands of dollars (Rosenthal 2014a, 2014b, Sanger-Katz and Abelson 2016). They are also unexpected by patients who reasonably assume that because they chose in-network hospitals for care, they would also be treated by in-network emergency physicians. Moreover, even when an insurer pays the entirety of a physician's out-of-network charges, those higher costs will be passed onto consumers via an increase in premiums and higher cost sharing (since patients will pay a fixed percentage of the physician's charges, rather than a fixed percentage of in-network rates).

More generally, the ability to successfully execute an out-of-network strategy creates a powerful outside option for ED physicians in their negotiations with insurers. If an insurer fails



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to offer a high enough in-network rate, ED physicians working inside in-network hospitals can refuse to contract with the insurer, treat patients out-of-network, and bill patients for their charges. Because patients cannot avoid out-of-network physicians in their chosen hospital, ED physicians who go out-of-network will not face any reduction in the number of patients they treat. This stands in contrast to other healthcare providers, such as primary care physicians, who will see a reduction in their patient volume if they do not join insurers' networks. Theory predicts that the availability of a lucrative outside option will give ED physicians bargaining leverage that will allow them to raise their in-network payment rates.[1] These higher payment rates, caused not by supply or demand, but rather by the ability to "ambush" the patient, represent a transfer from consumers to physicians and raise the cost of health care.

In this paper, we analyze data from a large insurer that covers tens of millions of lives annually to study where and why out-of-network ED billing occurs, to examine how it impacts in-network payment rates, and to test policy solutions designed to protect consumers. Our data cover nearly $28 billion in emergency spending on 8.9 million ED episodes from 2011 through 2015. We find that out-of-network physicians charge, on average, 637 percent of what the Medicare program would pay for identical services, which is 2.4 times higher than in-network payment rates. Consistent with the benefits of having a stronger outside option, we find that ED physicians in our data are paid in-network rates of 266 percent of Medicare payments, which is higher than what most other specialists are paid (for reference, in our data, in-network orthopedic surgeons are paid 178 percent of Medicare rates to perform hip replacements).

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In previous research, Cooper and Scott Morton (2016) found that 22 percent of privately insured patients treated at in-network hospital EDs were treated by out-of-network ED physicians. In this paper, we show that focusing on the average frequency of out-of-network billing nationally masks important heterogeneity in out-of-network rates across hospitals. Out-of-network billing is concentrated in a small number of hospitals. We find that 50 percent of hospitals have out-of-network billing rates below two percent while 15 percent of hospitals have out-of-network billing rates above 80 percent. This paper explores the reasons for this heterogeneity and discusses the policy response that it requires.

Approximately two-thirds of hospitals in the US outsource the staffing of their EDs to physician management firms that hire and manage physicians, manage ED operations, and take

[1] For a description of this result, see Osborne, Martin and Ariel Rubinstein (1990).



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care of billing (Deutsche Bank 2013). We analyze the behavior of the two largest ED outsourcing firms in the US: TeamHealth and EmCare. We find that the firms employ very different out-of-network strategies. However, we ultimately observe that both firms profit from the fact that out-of-network physicians working in in-network hospitals cannot be avoided by patients. The differences in how EmCare and TeamHealth use out-of-network billing to raise revenue are interesting in their own right. In addition, they offer insight into the economics of bargaining between physicians and insurers.

Across our-sample, EmCare-managed hospitals have an average out-of-network ED physician billing rate of 62 percent. Looking at data from 2011 to 2015, we find that after EmCare took over the management of emergency services at hospitals with previously low out-of-network rates, they raised out-of-network rates by over 81 percentage points. In addition, the firm raised its charges by 96 percent relative to the charges billed by the physician groups they succeeded. Some of this increase in physician charges is the result of a 43 percent increase in the rate the company coded for physician services using the highest acuity (highest paying) service code. Ultimately, we observe that the total payments made to EmCare by the insurer who contributed our data increased by 122 percent after EmCare entered a hospital. We also observe that patients faced an 83 percent increase in their cost sharing after the firm entered a hospital. Consistent with predictions from the model we present, we also find evidence that the firm compensated hospitals for allowing them to engage in an out-of-network strategy from inside their facilities. This transfer took the form of an 11 percent increase in facility payments after EmCare entered a hospital, which was driven by increases in the rates patients received imaging studies and were admitted to the hospital by EmCare physicians.

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Interestingly, TeamHealth, which has an average out-of-network billing rate of 13 percent, uses the threat of out-of-network billing to secure higher in-network payments. On average, we observe that after TeamHealth entered a hospital, out-of-network rates increased by 33 percentage points. However, in most instances, several months after going out-of-network, TeamHealth physicians rejoined the network and received in-network payment rates that were 68 percent higher than previous in-network rates. This is an example of the firm using a now-credible threat of out-of-network billing to gain bargaining leverage in their negotiations over in-network payments. Consistent with theory and our model, the TeamHealth in-network price is lower than the EmCare out-of-network price. In contrast to what we observed for EmCare, the



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entry of TeamHealth is not associated with an increase in the rate imaging studies are performed, the rate patients are admitted to the hospital, or the rate that physicians bill using the highest paying billing code for emergency care. Instead, we find that the entry of TeamHealth led to a 30 percent increase in the number of cases treated per year in entry hospitals' EDs.

What hospitals would allow physician groups working inside their facilities to engage in and out-of-network billing strategy given that it exposes patients to financial risk? Newhouse (1970) posited that hospitals trade off patient and community benefit with profits. Theory predicts that hospitals that place a lower weight on patient welfare relative to profits will have more out-of-network billing. While there is ambiguity about the objective function of non-profit hospitals, we would expect for-profit firms to be, ceteris paribus, more willing to prioritize profits ahead of community benefit and contract with firms that deliberately go out-of-network. Consistent with these predictions, we find that for-profit hospitals have higher out-of-network billing rates. In addition, whereas 19 percent of hospitals in our sample are for-profit, 56 percent of the hospitals that contract with EmCare are for-profit ventures.



Finally, we use our data to study the impact of a 2014 New York law that was designed to protect fully-insured patients from surprise out-of-network bills. The law requires that patients pay no more than their standard in-network cost sharing rates during an emergency, even if they are treated by an out-of-network provider. The law also prohibits balanced billing. In order to determine the rate that insurers pay physicians for out-of-network ED services, the law created a binding, "baseball rules" arbitration process to settle payment disputes that could not be resolved by the insurers and physicians directly. We find that the New York law lowered the incidence of out-of-network billing by 34 percent. Unfortunately, because states cannot regulate administrative services only (ASO) plans, the New York law applies only to the 40 percent of the privately insured population that is covered by a fully-insured health insurance product. However, the "baseball rules" effectively protect ASO patients, as we show below. Importantly, the law does not fix the underlying problem of ED physicians being shielded from competition. We close the paper by outlining a broader policy solution that would apply to all forms of insurance (fully-insured and administrative-services only products). We propose that either states or the federal government require hospitals to sell and insurers to purchase an "ED package" of emergency medical care that includes both hospital and physician services. This change in contract structure would generate competition in insurance, hospital, and physician markets,

eliminate out-of-network billing, and protect consumers

This paper is structured as follows. Section 2 gives background on ED care in the US and describes the impact of surprise out-of-network billing on patients. In Section 3, we describe our data and approach to identifying hospitals that contracted with EmCare and TeamHealth. In Section 4, we model the incentives of physicians and hospitals to engage in out-of-network billing. In Section 5, we identify the factors associated with out-of-network billing and analyze the impact of the entry of EmCare and TeamHealth on out-of-network billing, out-of-pocket costs, and hospital behavior. Section 6 analyzes the impact of a New York State law designed to end out-of-network billing. In Section 7, we propose our own policy to address the issue. We conclude in Section 8.

## 2. Background

### *2.1 The Evolution of Emergency Medicine in the United States*

From the 1970s through the 1990s, care in hospital-based EDs shifted from being provided on an ad hoc basis by community physicians to being delivered, round-the-clock, by doctors who often completed residencies in the specialty of emergency medicine and who obtained board-certification in the specialty (Institute of Medicine 2006).[2] At present, there are more than 4,500 EDs in the US and approximately 40,000 physicians who staff them nationwide (Hsia et al. 2011; Morganti et al. 2013). The use of EDs has risen dramatically over time. From 1993 to 2003, the U.S. population grew by 12 percent, hospitalizations increased by 12 percent, and ED visits increased by 26 percent (Institute of Medicine 2006). From 2001 through 2008, the use of EDs increased 1.9 percent each year—60 percent faster than concurrent population growth (Hsia et al. 2011).

Over the last several decades, EDs have become one of the main pathways through which patients are admitted to the hospital (Morganti et al. 2013). From 1993 to 2006, the share of all inpatient stays in which patients were admitted to the hospital via an ED increased from 33.5 percent to 48.3 percent (Schuur and Venkatesh 2012). Over time, as the use of EDs has gone up, waiting times to be treated in EDs have also increased (Hing and Bhuiya 2012). In response to rising waiting times, EDs increasingly are competing on the length of time patients have to wait

[2] Many EDs are not staffed by board-certified ED physicians. Approximately a third of emergency care is provided by family physicians. In rural states, the share of family physicians delivering emergency care is higher than 50% (Wadman et al. 2005; Groth et al. 2013; McGirr et al. 1998).

before they are treated (Esposito 2015, Rice 2016). Because EDs have become a major source of patients, hospitals now want to keep their EDs open at all hours and run them efficiently (Institute of Medicine 2006, Morganti et al. 2013). As a result, there has been a marked increase in the outsourcing of management of hospital EDs. ED outsourcing companies hire and manage physicians, manage ED operations, and take care of billing. At present, roughly 65 percent of the physician market is outsourced (Deutsche Bank 2013). Among the hospitals that outsource their services, approximately a third contract with a large, national outsourcing chain and the remainder are outsourced to smaller, local firms (Dalavagas 2014). Two leading national outsourcing firms—EmCare and TeamHealth—collectively capture approximately 30 percent of the physician outsourcing market (Deutsche Bank 2013).

In the aggregate, ED care is profitable for hospitals. Wilson and Cutler (2014) estimated that average ED profit margins are approximately 7.8 percent per patient. However, the profit margins that hospitals face for ED care vary significantly depending on how a patient's care is funded and based on whether a patient is admitted to the hospital. Wilson and Cutler (2014) found that hospitals had profit margins of 39.6 percent for privately insured patients treated in EDs, whereas the profit margin for patients covered by Medicare and Medicaid and those uninsured was –15.6 percent, –35.9 percent, and –54.4 percent, respectively. They also found that patients who were admitted to the hospital were significantly more profitable than those who were not. For Medicare patients, the profit margin on ED care for patients who were discharged from the ED was –53.6 percent whereas the profit margin for patients who were admitted to the hospital was 18.4 percent (Wilson and Cutler 2014).




*2.2 Out-of-Network Surprise Billing*

There has been significant coverage of out-of-network billing in the popular press (Rosenthal, 2014a, 2014b, Sanger-Katz and Abelson 2016). However, until recently, there has been no systematic evidence on the frequency that out-of-network billing occurs. Recent survey work suggests that it is fairly common for privately insured patients to be treated by out-of-network physicians. A Consumers Union (2015) survey found that 30 percent of privately insured individuals reported receiving a surprise medical bill within the previous year, and Kyanko et al. (2013) found that most instances in which privately insured individuals involuntarily saw out-of-network providers occurred during medical emergencies. In many instances, when patients

receive a surprise bill, they simply pay the balance in full (Consumers Union 2015). Likewise, among those who had trouble paying a medical bill, 32 percent reported that their financial troubles stemmed from a bill from an out-of-network provider for services that were not covered or were only partially covered by their insurer (Hamel et al. 2016). In this Hamel et al. (2016) survey, the authors found that bills from ED physicians made up the largest share of medical debt that patients reported having problems paying.

The results of these surveys have been confirmed by recent empirical evidence. A 2014 report found that among the three largest insurers in Texas, 45 percent, 56 percent, and 21 percent of their in-network hospitals had *zero* in-network ED physicians (Pogue and Randall 2014). Likewise, in the first national study of out-of-network billing, Cooper and Scott Morton (2016) analyzed data from a large commercial insurer and found that 22 percent of in-network ED hospital visits included a primary physician claim from an out-of-network doctor. Using completely different data, Garmon and Chartock (2017) found that 20 percent of ED cases in which care was delivered to privately insured patients at in-network hospitals involved care form an out-of-network physician. As we will show below, knowing the average propensity of receiving an out-of-network bill does not help diagnose the policy problem, which lies in the tail of the distribution of out-of-network billing rates across hospitals.





It is clear that most patients face higher co-insurance rates when they see out-of-network physicians, can be balanced billed, and, in some instances, may be wholly responsible for the cost of their visit. As we show later from our data, these physician bills can be extremely large. Unfortunately, there is no systemic evidence on the frequency that patients are balance billed or exposed to the full costs of an episode of care. However, reports from regulators in Colorado and New York indicate that this practice does occur and can expose patients to significant financial risk (Department of Financial Services 2012, Department of Regulatory Agencies 2010). Likewise, data from the Texas Department of Insurance showed that balance-billing complaints in the state increased 1,000 percent from 2012 to 2015 (Gooch 2016).

## 3. Data and Descriptive Statistics on Out-of-Network Billing

### *3.1 Data*

Our claims data come from a large commercial insurer that covers tens of millions of lives annually. The data run from January 1, 2011, through December 31, 2015. The data are

structured at the service-line level and include detailed patient characteristics, a provider identifier, and the ability to link to a range of third-party datasets. We define ED episodes as those with a physician service line that includes a Current Procedural Terminology (CPT) code for emergency services and a hospital revenue code associated with an emergency visit.[3] We limit our analysis to episodes that occurred at hospitals registered with the American Hospital Association (AHA). Therefore, we do not include, for example, treatment that was delivered at urgent care clinics.

At baseline, our data include 13,444,445 episodes. We introduce several sample restrictions to our data to produce an analytic dataset. First, we exclude episodes that were missing an AHA hospital ID or did not come from an AHA-identified hospital. Thus, the analysis is focused only on hospital-based ED care. This restriction eliminates 1,908,710 episodes. Second, we exclude episodes for which the same physician billed as in-network and out-of-network on separate service lines on the same claim form. This restriction eliminates 264,636 episodes. Third, we exclude episodes with duplicative insurer payments, episodes with insurer payments that were negative, and episodes for which the insurer paid $0 because the claims were denied. This restriction removes 217,267 episodes. Fourth, we exclude episodes for which the start date of the episode occurs after the end date of the episode. This restriction excludes 79 episodes. Fifth, we limit our analysis to hospitals that delivered 10 or more episodes per year and appear in all five years of the data. This restriction excludes 330,312 episodes. Sixth, we limit our analysis to individuals who had six months of continuous enrollment before their emergency episode.[4] Having six-months of historical data is necessary to create our Charlson comorbidity scores. This restriction excludes 1,810,245 episodes from our analysis. Finally, we winsorize the top and bottom 1 percent of the prices in our data.[5] We do this to limit the influence of idiosyncratically high- and low-priced episodes.

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In our data, we observe the amount the ED physician and hospital submitted as a charge, the amount that the insurer paid, and patients' co-insurance payments, co-payments, and spending under their deductibles. We define the total amount an ED physician was paid as the

[3] We identify ED claims for physicians as those that include a CPT code of 99281, 99282, 99283, 99284, 99285, or 99291 and a hospital service line as those with a revenue code of 0450, 0451, 0452, 0453, 0454, 0455, 0456, 0457, 0458, or 0459. We require episodes in our analysis to have a physician service line with an ED code and a facility service line with an ED code.

[4] We did so because we wanted to have the ability to control for patients' historical spending and comorbidity.

[5] Our results are robust to not winsorizing prices, but there are extremely large hospital and physician charges and payments.



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sum of the insurer payment, the patient co-insurance payment, the patient co-payment, and the patient deductible on physician service lines that have a CPT code for emergency services.[6] We calculate facility payments as the sum of the insurer payment, patient co-insurance, patient co-payment, and patient spending under her deductible summed across all facilities claims. All prices are put in 2015 dollars using the U.S. Bureau of Labor Statistics Consumer Price Index.

Unfortunately, we do not observe whether patients were balanced billed by physicians. Therefore, it is possible that the physician collects more in total than we can measure. To our knowledge, there are no datasets with information on the balance billing of patients. However, we construct a potential balanced bill measure that is the difference between what the physician charged and the sum of what the physician was paid by patients (in the form of cost-sharing) and by the insurer. We also create a measure of patients' potential total cost exposure, which we calculate as the sum of the potential balanced bill and their out-of-pocket costs.

In addition, we construct an indicator for whether or not imaging occurred during an episode based on whether or not there are facility claims with revenue codes associated with imaging studies.[7] Likewise, we identify episodes as involving an admission to the hospital if the facility claim for the episode includes a revenue code for room and board fees.[8]





For each episode, we also observe the patient's sex, age (measured in 10-year age bins), and race (white, black, Hispanic, and other). We also use our claims data to measure historical patient spending for six- and 12-month periods preceding an episode. Because we do not want the emergency episodes we are analyzing to feed into the historical spending measures, we measure spending from two weeks before the admission date for an episode back six and 12 months. In addition, we used six and 12 months of claims data to calculate Charlson measures of comorbidity (Charlson et al. 1987).[9]

### *3.2 Identifying Where EmCare and TeamHealth Have Contracts*

The national market for physician outsourcing is dominated by two firms that collectively account for approximately 30 percent of the outsourced physician market. EmCare is publicly

[6] These are service lines with a CPT code of 99281, 99282, 99283, 99284, 99285, or 99291.
[7] We identified episodes that included imaging studies based on whether or not the facility claims had a service line with the revenue codes 350–352, 610–619, 400–404, or 409.
[8] We identified room and board fees based on the following revenue codes on facility claims: 100, 101, 103, 110–160, 164, 167, 169–176, 179, 190–194, 199–204, 206–214, 219, 658, or 1000–1005.
[9] We pooled individuals with a Charlson score of 6 and higher.

traded, operates in 45 states, has 23,100 affiliated or employed physicians and health care professionals, and according to their 2016 Form 10-K, delivers more than 18 million emergency episodes per year. More recently, EmCare has partnered with a large, for-profit hospital chain and formed joint ventures where the firm and its hospital partners share in profits from physician bills (Deutsche Bank 2013).

The second firm, TeamHealth, is approximately the same size. According to the firm's 2015 Form 10-K, TeamHealth has more than 18,000 affiliated health professionals and delivers approximately 10 million ED cases per year. TeamHealth recently acquired another physician outsourcing company and now is likely to have the largest market share in the physician outsourcing space. The firm was previously publicly traded but was taken private in 2016.

EmCare and TeamHealth bill using their contracted physicians' National Provider Identifier (NPI) numbers. As a result, our claims data do not indicate that a particular claim is being billed by a physician employed by one of these firms. To identify the hospitals where EmCare and TeamHealth have outsourcing contracts, we use data from the firms' own webpages and documents. We require two independent sources of information to classify a hospital as a facility that outsourced its ED services to EmCare or TeamHealth.

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We rely on maps with approximate firm locations to provide the first source of information on which hospitals are affiliated with EmCare and TeamHealth. Envision, the parent company of EmCare, posted a map on the company webpage that included the approximate location of each location where EmCare has a contract (see Appendix Figure 1A). The map on the Envision webpage included embedded latitudes and longitudes within the webpage's underlying code, which we use to identify hospitals. Likewise, we use a map from TeamHealth's initial public offering in 2009 that shows the locations where TeamHealth had contracts in 2009 (TeamHealth 2009) (see Appendix Figure 1B). To identify hospital locations on the TeamHealth map, we scraped the map using mapping software from ArcGIS.[10]

The second source of information we use to identify hospitals that contract with EmCare and TeamHealth came from job advertisements posted by the firms. Each firm posts job advertisements for physicians on their respective webpages (see an example in Appendix Figure

[10] To obtain the latitudes and longitudes of the hospital locations displayed on the Morgan Stanley Report map, we utilized georeferencing within ArcMap. This technique aligns a map with a known coordinate system to the map of interest (which has no identified coordinate system). After transforming and overlaying the two aligned maps, we then obtain coordinate estimates of each marked hospital within a reasonable range of accuracy.



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2). The job advertisements include the name of the hospital where physicians are being recruited and the specialty of the physicians the hospital is looking to hire. We scraped the names of the hospitals and the specialty of the physicians being recruited from all job postings that were available from the firms' webpages and webpage histories.

Ultimately, we identify a hospital as having a contract with EmCare or TeamHealth if we are able to identify the hospital on a map of the outsourcing firms' locations and we found a job hiring post for the hospital. This strategy exploits the fact that, in general, these firms wholly take over an ED and participate in exclusive contracts with hospitals (Deutsche Bank 2013).

Using this strategy, we find 194 hospitals associated with EmCare and 95 hospitals affiliated with TeamHealth. As a result, of the 3,345 hospitals in our analysis that meet our sample criteria, 5.8 percent outsource their ED to EmCare and 2.8 percent outsource their ED to TeamHealth. Based on investor reports on EmCare and TeamHealth, our sample of hospitals with contracts with EmCare and TeamHealth represents an undercount of the total population of hospitals that have contracts with EmCare and TeamHealth.

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We also use the entrance of physician management companies into hospitals to estimate the causal effect the entry of TeamHealth and EmCare had on physician pricing and hospital behavior. To do so, we identify hospitals where these firms entered into an outsourcing contract from 2011 to 2015. To identify the hospitals where EmCare and TeamHealth entered into outsourcing contracts, we searched both companies' webpages for press releases announcing new contracts. Likewise, we used LexusNexus and Google to search the popular press for news stories that announced when either EmCare or TeamHealth entered into a contract with a hospital. Using this strategy, we find evidence that during our time period (2011 through 2015), EmCare entered into contracts with 16 hospitals that were part of nine health systems while TeamHealth entered into contracts with 10 hospitals that were part of six systems (see Appendix Table 1).

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**4. Modeling Surprise Out-of-Network Billing**

For it to occur, there are three parties that have to prefer out-of-network billing to an in-network contract: the physician group, the hospital, and the insurer. The physician group and insurer must be unable to come to an agreement on an in-network contract. In addition, the hospital must



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effectively allow physicians to bill out-of-network from inside their facilities.[11] We discuss each party's incentives in turn.

*4.1 Out-of-Network Prices*

The physician group and the insurer bargain over the price the insurer will pay the physicians. The revenue component of the disagreement payoff of the physician group should it end up out-of-network is a price limited only by the laws of a state, $s$. Since state laws differ, this net price will vary by state, and we could think of the price as being a function of that state's institutional environment, e.g. $p = f(law_s)$.[12] However, the model below will focus on agents all in one state and describe the average out-of-network price the group can collect, $p^L$, as coming from the legal environment, not the market environment in that state. A crucial feature of emergency medicine (that our model exploits) is that the quantity of patients seen by the emergency physician group is invariant to its network status.[13]

*4.2 Insurers*

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We denote the equilibrium negotiated price as $p^*$. We abstract from all other revenue and costs of the insurer and simply define $r$ to be the insurer's net revenue per patient without any ED physician cost. Thus, the net benefit of a representative enrollee to the plan is $r$ less the cost of the ED physician. If the physician group and the insurer agree to a contract at $p^*$, the insurer gets:

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$$U_{i,IN} = r - p^*. \quad (1)$$

If the two parties do not agree, then the physician group begins billing its charges, which are higher than negotiated network rates. The insurer may take advantage of any state law to reduce those physician charges, but the laws result in an effective price received by the physicians of $p^L$.

[11] The hospital may not have legal authority to prevent a physician (or physician group) from practicing in the ED just because that physician has failed to come to an agreement with any given insurer or insurers. However, we assume there are so many interactions between the hospital and an ED physician group that if the hospital disapproved of the group's overall strategy, it could make the relationship sufficiently onerous such that the physicians would move in-network.

[12] In Maryland and California, for example, out-of-network physicians cannot bill more than the greatest of either their in-network payments, a fixed percentage of Medicare payments, or physicians' usual and customary charges.

[13] When patients attend a hospital ED, they have no choice over the physician that treats them. As a result, once a patient decides to attend a hospital ED, the patient cannot avoid out-of-network physicians working in that ED. Previous researchers have used this feature of emergency medicine as a source of random variation in physician assignment (see: Barnett, Olenski, and Jena 2017, Chan 2015).



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We assume that the insurer ends up paying some fraction $\gamma$, less than one of the new out-of-network price $p^L$. We will treat $\gamma$ as exogenous in our model.[14] The net insurer payoff under disagreement is thus:

(2) $$U_{i,OUT} = r - \gamma p^L.$$

A second difference under disagreement is that now the physicians also collect the balance of the payment from the patient, who earns a disutility payoff $W\big((1-\gamma)p^L\big) < 0$. The patient blames the hospital for the balance bill so the hospital suffers harm to its reputation of $k_h$. Throughout the model, when we use the term "out-of-network billing" we are referring to physicians using the deliberate strategy of raising charges by a significant amount in order to earn higher payments. It is perfectly possible for an ED physician group to not have a contract with a patient's insurer (perhaps due to transaction costs) and to charge that patient a typical in-network price. We assume, as is the case in our data, that in this situation the patient and the insurer will share costs in the usual way and there are no disputes. We further assume that in that case there is no reputational cost to the hospital. While this setting is technically also "out-of-network billing," we exclude it from the definition in our discussion below in order to focus on the deliberate strategy of raising prices.

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*4.3 Hospitals*

We assume that hospitals understand when their outsourcing firm will be taking advantage of patients and insurers with an out-of-network billing strategy. Hospitals appreciate that the management company cannot carry out its strategy without access to the ED, and therefore the hospital will be able to bargain to keep a share of the increased profits generated by the outsourcing firm. These profits could take the form of physicians allowing the hospitals to share in the physicians' profits (e.g., with a joint venture), through a reduction in any management fees that a hospital would have to pay a firm to staff their ED. The payment could alternatively be generated by increases in facility fees that result from increased testing rates, imaging rates, or admissions to the hospital. Recall that, ultimately, physicians control patient utilization and what gets billed by the hospitals. As a result, ED physicians have significant influence over hospitals' revenue.

[14] It could be that $\gamma$ is determined by state laws and norms as well as by competition in the insurer market. We assume that frictions in the physician ED market are too small to create any feedback to insurance competition.



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Because the hospital can block an out-of-network billing strategy, it must be compensated for the reputational loss it incurs from having this practice occur inside its facility. We assume that an outsourcing firm can pay a fixed amount $c > k_h$ to satisfy the hospital.[15] Physicians also have the ability to generate payment *c* to the hospital without it coming from the physician's own pocket. This could occur via potentially unnecessary activities $A$ such as ordering additional lab testing, imaging studies, or raising the rates that patients are admitted to the hospital. Increasing these activities does not generate revenue for the physician, but it does generate revenues to the hospital. Engaging in activity $A$ carries with it some legal risk indicated by $R(A)$, (with $R'(A) > 0$, $R(0) = 0$), since it potentially involves giving care to patients who don't need it which could be found to violate laws or regulations. A more complex model could make $c$ endogenous and allow outsourcing firms to compete by increasing it, but we do not take on that topic in this paper.

We also assume the hospital does not face any cost of higher-priced *in-network* billing. We think this is a reasonable assumption because it is hard for patients to observe counterfactual prices and patients perceive they are 'covered' in these circumstances. That is, the level of $p^*$ paid to ED physicians when they participate in an insurer's network does not affect the hospital's payoff. Hospitals value consumer welfare and also profits with weight $\alpha_h$. If a hospital hires an out-of-network group to staff its ED, hospital utility changes by:

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$$\Delta U_h = (c - k_h) + \alpha_h W((1-\gamma)p^L), \tag{3}$$

which represents its incremental financial earnings less the dollar value of the disutility of patients. The hospital will only agree to out-of-network billing if its weight $\alpha_h$ on patients is sufficiently low. Recall that $W < 0$ and $c > k_h$, so $\alpha_h$ will be positive but smaller, all else equal, for hospital willing to engage in out-of-network billing:

$$\alpha_h < (c - k_h)/(-W\big((1-\gamma)p^L\big)). \tag{4}$$

If a hospital experiences a very high reputational or other cost to hosting a physician group engaged in an out-of-network billing strategy, physician groups will find it expensive to locate their strategy in that hospital and will tend to locate elsewhere. In the empirical section of

[15] We recognize a possible role for asymmetric information. A hospital may not realize the strategy of the outsourcing firm *ex ante*. An uniformed hospital may sign a contract that is later terminated when the hospital realizes its patients are receiving balance bills and the reputational cost is high. For example, the Los Alamos Medical Center began contracting with EmCare in 2012 (DeRoma 2012). Several years later, the hospital ended their contract with the hospital over concerns about out-of-network billing and coding practices.



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the paper we will identify the characteristics of hospitals that have high out-of-network rates and contract with firms that engage in an out-of-network billing strategy.

*4.4 Physicians*

A physician group faces a tradeoff between exercising its threat of going out-of-network and collecting $p^L$ while compensating the hospital $c$ (or engaging in $A$) and having a disutility from financially harming patients, or joining the network for $p^*$. Consumer welfare, $W$, is constant at zero across in-network prices because we assume the impact of out-of-network billing on premiums takes place slowly over time and is not perceived by consumers within our game. Out-of-network billing from a patient's doctor results in disutility to that patient of $W\big((1-\gamma)p^L\big)$ which the physicians also take into account with a weight $\alpha_p$.

Physicians value profits, consumer welfare, and legal risk with weights as noted below. Profit is the negotiated price times a fixed quantity of patients less any financial costs due to the physician group's choice. If out-of-network status is chosen, the group must either pay the hospital the financial cost $c$ or bear risk $R(A)$, which is a decrement to the physicians' utility weighted by $\beta_p$. Physician per patient utility (the number of patients is fixed) when bargaining fails is:



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(5) $$U_{p,OUT}(\pi, W, A) = p^L + \alpha_p W\big((1-\gamma)p^L\big) - \min\{c, \beta_p R(A)\}.$$

We assume that everywhere physicians' gain from an additional dollar increase in $p^L$ is larger than their utility loss from the harm to consumers. Physicians' increased utility from income can be offset by harm to consumers, but not reversed. This is particularly plausible when $\gamma$ is large, which is the case in our setting.[16] We therefore assume $\left|\alpha_p W'\right| < 1$.

When bargaining succeeds and the physician group is in-network at the hospital, its utility is:

(6) $$U_{p,IN}(\pi, W, A) = p^*.$$

We assume equal bargaining power for the two parties. The Nash bargaining expression is therefore the product of the gains from agreement for both parties:

(7) $$\left[U_{p,OUT} - U_{p,IN}\right] * \left[U_{i,IN} - U_{i,OUT}\right].$$

[16] Few consumers have savings to pay a large medical bill and therefore the fraction of it that can be actually collected by physicians is relatively small.



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Which can equivalently be written:

(8) $$\left[p^* - p^L + \alpha_p W\left((1-\gamma)p^L\right) - \min\{c, \beta_p R(A)\}\right] * [\gamma p^L - p^*].$$

We assume bargaining strengths are equal and therefore $p^*$ will split any difference between the two outside options. If the following holds:

(9) $$U_{p,OUT}(\pi, W, A) = p^L + \alpha_p W\left((1-\gamma)p^L\right) - \min\{c, \beta_p R(A)\} \geq \gamma p^L,$$

then there are no gains from a contract and the physician group will stay out-of-network. On the other hand, if:

(10) $$U_{p,OUT}(\pi, W, A) = p^L + \alpha_p W\left((1-\gamma)p^L\right) - \min\{c, \beta_p R(A)\} < \gamma p^L,$$

then we expect an equilibrium $p^*$:

(11) $$p^* = [p^L + \alpha_p W\left((1-\gamma)p^L\right) - \min\{c, \beta_p R(A)\} - \gamma p^L]/2$$

The intuition for the case where an in-network price is possible is graphed below. The key is that the physician's net utility for being out-of-network is low, either because of concern for patient welfare or because the hospital's reputational cost, and therefore transfer, is high. Alternatively, if $U_{p,OUT}$ (measured in dollars) lies above $\gamma p^L$ on the line below, either because physicians are not concerned about putting patients in a bad situation or hospital reputation costs are low, then there is no scope for agreement.

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The insurer's outside option ($\gamma p^L$) is not specific to an insurer but is constant across all insurers due to state law. Equilibrium $p^*$ will fall in between the two outside options when $U_{p,OUT}$ is low enough. In the case when there is possibility of an agreement, if the law or other forces raise the insurer's out-of-network payment, the equilibrium negotiated price will increase. We can check if an increase in $p^L$ will raise the equilibrium negotiated rate by taking the derivative of the expression for $p^*$ with respect to $p^L$ and asking if it is positive.

(12) $$1 - \gamma + (1-\gamma)\alpha_p W' > 0$$

We know $W'$ is negative (a higher payment paid by consumers makes their utility more negative) and we also know $|\alpha_p W'| < 1$ by our assumption above. Since $(1-\gamma)$ is positive, the derivative is therefore positive.

Take the case where physicians put no weight on legal risk or patient disutility. In that case the physician payoff is $p^L$ (they choose activity $A$ and do not pay $c$) and there is nothing the



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insurer can offer as an in-network price that will be attractive. The physicians will stay out of the network, insurers will pay $\gamma p^L$ and patients will pay the balance. As physicians' disutility for risk, $c$, and weight on patients all rise, the outside option for the physician group becomes worse and eventually will fall below $\gamma p^L$ whereupon there is scope for an in-network rate that benefits both sides.

Out-of-network physician groups will choose between paying $c$ or engaging in activity $A$ according to whichever is cheaper, which will depend on their risk tolerance $\beta_p$. Physician groups with low $\alpha_p$ and high $\beta_p$ want to choose the out-of-network strategy but do not want the risk of activity $A$ and therefore must pay the hospital directly. Physician groups with low $\alpha_p$ and low will $\beta_p$ choose the out-of-network billing strategy for the additional profit, and pay the hospital through activity $A$ which they find relatively cheap compared to giving up profit.

Much of the empirical analysis in our paper concerns the change when the outsourcing firm takes over the ED group. This can be incorporated into the model in two ways. First, we could think of the management company causing an increase in the effective bargaining power of the physician group. Instead of each having 0.5 weight, we could model the company as making take-it-or-leave it offers to the insurer. Alternatively, the outsourcing company could improve the information of the physicians by, for example, providing data on how large out-of-network bills can be under the law. Out-of-network billing was always an option in this scenario, but the prior physician group may not have been aware of its profitability. This might be because before the outsourcing firm arrived, the physician group lacked professional management, felt excessive concern that the group could be easily replaced by the hospital, had a lack of knowledge of the cost of collecting and litigating large bills, lack of knowledge of state law and regulation, and so forth. We can think of the outsourcing firm as bringing to bear its knowledge of "best practices" in terms of out-of-network billing, its costs, collection procedures, relevant state law, etc. This kind of change in information would raise the $p^L$ perceived by the physician group and change the game that way.

We take the model above to the data as follows. We expect to see that for-profit hospitals have a higher level of out-of-network billing and a higher propensity to contract with EmCare than non-profit hospitals because their weight on patient welfare is lower. We also expect that in-network prices for ED physicians will be higher relative to in-network rates in other specialties where out-of-network billing is not an option. And further, we expect that in-network prices will



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be higher when the threat of moving out-of-network is credible, which occurs when the ED physicians are managed by an outsourcing company. Lastly, the out-of-network payment to ED physicians who remain out-of-network will be higher than all types of in-network prices.

## 5. Out-of-Network Billing, Physician Prices, and Hospital Outsourcing

### *5.1 Descriptive statistics on ED Physician Payments and Out-of-Network Billing Rates*

Our final dataset is composed of 8,913,196 ED episodes delivered between January 1, 2011 and December 31, 2015 (see Table 1).[17] This represents nearly $28 billion in emergency spending. Over 99 percent of ED cases in our data occurred at an in-network hospital. As we illustrate in Table 1, the average in-network ED physician payment across our sample period was $325.91 (266 percent of what the Medicare paid for the same services). The amount ED physicians were paid increased as a percentage of Medicare over our time period. During this period patient out-of-pocket costs for emergency care also steadily increased and the average total out-of-pocket cost for an emergency episode (combining the physician and facility component) was $467.75. Appendix Table 2 includes descriptive statistics for our analytic sample of ED episodes.

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At the average in-network hospital in our data, 25.8 percent of patients treaded in the ED were treated by an out-of-network ED physician (Table 1). The frequency that patients at in-network hospitals were treated by out-of-network ED physicians has declined over time from 28.6 percent in 2011 to 21.9 percent in 2015. However, this average masks significant heterogeneity in out-of-network billing rates across hospitals and is somewhat misleading. Figure 1 shows the distribution of out-of-network billing rates across hospitals in our data in 2015 and summary statistics for that year. It illustrates that out-of-network billing is highly concentrated in a small group of hospitals. As we illustrate, 50 percent of hospitals have out-of-network billing rates below two percent. In contrast, the out-of-network billing rate for hospitals in the 75$^{th}$ percentile of the distribution of out-of-network billing rates was 28 percent and 15 percent of hospitals have out-of-network rates of higher than 80 percent. This skewed distribution is evident in 2011, 2013, and 2015 (see Appendix Figure 3).

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### *5.2 Cross-Sectional Analysis of Hospitals' Out-of-Network Billing Rates*

[17] Seventy-seven percent of individuals with an ED episode had insurance from an administrative services only (ASO) insurance product and the balance had coverage from fully insured plans.



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To assess the factors associated with the variation in hospitals' out-of-network billing rates, we follow the approach of Finkelstein et al. (2016) and run a least absolute shrinkage and selection operator (Lasso) regression on a range of hospital, local area, physician market, and hospital market characteristics (a complete list and descriptions of the variables that we include in our first-stage Lasso are available in Appendix 1). We also include indicator variables for whether or not EmCare and TeamHealth had contracts with hospitals. The Lasso method applies a penalizing parameter to the coefficient of the explanatory variables included in the regression. We use 10-fold cross-validation to choose the penalizing parameter that minimizes the mean squared error. We use this Lasso procedure to select a set of variables that we include in a second stage where we determine their correlation with hospital out-of-network billing rates.

Figure 2 presents our conditional correlations between the variables selected using the Lasso regression and the share of patients per hospital that saw out-of-network physicians between 2011 and 2015 during an emergency. We also included several variables, which were not selected by the Lasso regression, but which our model indicates should be relevant. These variables include a measure of physicians per capita, and hospital, physician, and insurer HHIs.[18] The results in Figure 2 are correlates of hospital-level out-of-network billing rates and should not be interpreted causally. However, several of the correlations are consistent with the equilibrium described by our model.

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As Figure 2 shows, the presence of EmCare at a hospital is positively correlated with the hospital's out-of-network billing rate. In contrast, outsourcing a hospital's ED to TeamHealth is negatively correlated with the hospital's out-of-network billing rate. In addition, we find that non-profit hospitals, teaching hospitals, and government-owned hospitals have lower rates of out-of-network billing; for-profit hospitals have higher out-of-network billing rates. Larger hospitals and hospitals with better technology have lower rates of out-of-network billing. The share of total discharges funded by Medicare is positively correlated with out-of-network billing

[18] We created a hospital HHI for each hospital registered with the AHA. For each hospital, we drew a circle with a radius of 15 miles around the hospital. We calculated an HHI within that circular area where the total market was the total number of hospital beds within that area and a firm's market share was the firm's share of total beds in that area. We constructed insurer HHIs for each county using data from the HealthLeaders Insurance data. We defined the total market as the covered lives in the small and large group markets. A firm's market share was its share of the total lives in that county in the small and large group markets. We used physician HHIs measured at the county level, which we were graciously given by Loren Baker. The methods used to build these measures are described in Baker et al. (2014). We construct measures of physician per capita using physician information from the SK&A database and population data from the U.S. Census Bureau.



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rates. Finally, we find that areas with a higher fraction of married adults and low inequality have low out-of-network rates.

*5.3 Causal Estimates of the Effect of EmCare and TeamHealth on Hospital OON Rates*

Our cross-sectional results featured in Figure 2 suggest that out-of-network billing is significantly higher at hospitals that outsource their ED to EmCare. In this section, we estimate the causal effect that the entry of EmCare and TeamHealth had on the likelihood patients were treated by out-of-network physicians working inside in-network hospitals. To do so, we exploit evidence we collected from press releases, news stories on the firms' webpages, and articles in the popular press announcing the timing of the entry of EmCare and TeamHealth into hospitals. We then compare outcomes immediately before and immediately after EmCare and TeamHealth entered hospitals. In total, we analyze the entry of EmCare into 16 hospitals between 2011 and 2015 and the entry of TeamHealth into 10 hospitals during the same period. We begin by showing trends in the raw data of hospitals where EmCare and TeamHealth entered into management contracts. We follow that up with a regression-based analysis.

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Because EmCare and TeamHealth appear to have different strategies, we separately test the impact of their entries on billing practices and hospital and physician behavior. To do so, we estimate a hospital fixed effects model with an indicator variable ($EmCare_{i,t}$ or $TeamHealth_{i,t}$) that takes a value of 1 on and after the date that EmCare (or, in separate regressions, TeamHealth) entered a hospital and returns to zero on the dates that the firm exited hospitals if the firm lost a contract.[19] Our estimation takes the form:

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(13a) $$Y_{i,j,t} = \beta_0 + \beta_1 EmCare_{i,t} + \delta_j + \theta_t + \varepsilon_{i,j,t},$$

and

(13b) $$Y_{i,j,t} = \beta_0 + \beta_1 TeamHealth_{i,t} + \delta_j + \theta_t + \varepsilon_{i,j,t},$$

where we estimate the outcomes for episode $i$ that occurred at hospital $j$ at time $t$. We also include a vector of hospital fixed effects $\delta_j$ and a unique month dummy, $\theta_t$, for each month in the data. Our standard errors are clustered around hospitals. We interpret a discontinuous change in hospital behavior immediately following the entry of an outsourcing firm into a hospital as the causal impact of entry. We compare outcomes at hospitals where the two outsourcing firms

[19] We can estimate the impact of EmCare and TeamHealth entry in the same estimator, and we get nearly identical results.



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entered to outcomes at three sets of control hospitals: 1) all hospitals nationally that did not have EDs managed by EmCare or TeamHealth, 2) hospitals drawn from the same states where the hospitals that experienced entry were located but did not outsource their ED services to EmCare or TeamHealth, and 3) hospitals that were not managed by EmCare or TeamHealth that we matched to entry hospitals using propensity scores.[20] One obvious concern with our identification strategy is that treated and untreated hospitals may have differences in their trends in out-of-network billing rates, physician pricing, or hospital behavior prior to the entry of EmCare or TeamHealth. However, as we illustrate, when we plot the raw data from our treated hospitals, there do not appear to be any changes in behavior prior to the entry of those firms.

EmCare enters two types of hospitals (Appendix Figure 4A). The first group of hospitals has out-of-network rates over 97 percent. The second group has out-of-network rates below 10.1 percent. In Figure 3, we present a smoothed average using a local polynomial regression of the monthly hospital-level out-of-network ED physician billing rates from one year before EmCare (Panel A) and TeamHealth (Panel B) entered a hospital until one year after entry. In Panel A of Figure 3, the raw data show a clear increase in out-of-network billing rates at hospitals immediately after EmCare entered. For interested readers we present the raw, quarterly average out-of-network rates by hospital at each of the 16 hospitals that EmCare entered in Appendix Figure 5.[21] None of these graphs show marked changes in out-of-network billing rates before EmCare entered a hospital.

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We repeat this analysis using regression analysis Equation (13a) and report the results in Table 2. The indicator variable on entry identifies the causal impact that the entry of EmCare had on the prevalence of out-of-network billing. In Column (1) of Table 2, we focus on changes in out-of-network billing rates at hospitals that EmCare entered that previously had high out-of-network billing rates. After EmCare entered, there is no statistically significant change in the

[20] To calculate propensity scores, we ran a logistic regression separately for EmCare and TeamHealth where the dependent variable was an indicator variable that took a value of 1 if one of the national ED staffing companies took over management of the hospital's ED. We regressed that against hospital beds, technology, the square and cubic forms of beds and technology, and non-profit/for-profit status. The predicted values from this regression produce a propensity score for a hospital. We then use a propensity score match to determine hospitals most similar to those with entry, with the condition that matching hospitals must be in the same state.

[21] For nearly all hospitals that had previously high out-of-network billing rates (Panels I, J, K, L, M, N, O, and P of Appendix Figure 5), when EmCare entered, out-of-network billing rates remained high. In contrast, after EmCare entered hospitals that previously had low out-of-network billing rates, the likelihood a patient was treated by an out-of-network physician increased to nearly 100% immediately after EmCare entered the hospital (Panels A, B, C, D, E, F, G, H, of Appendix Figure 5).



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likelihood a patient was treated by an out-of-network physician. In Column (2), we estimate the impact of the entry of EmCare into hospitals with previously low out-of-network rates (the half of hospitals where the firm entered with OON rates below 10.1 percent). These results mirror what we observe in the raw data. We observe that the entry of EmCare into these hospitals raised out-of-network rates by 81.5 percentage points.[22] In Appendix Table 3, we show that these results are robust to using alternative control groups.

TeamHealth appears to pursue a different out-of-network strategy. The raw data from Panel B of Figure 3 shows that out-of-network billing rates increased immediately after the firm took over management of hospital EDs. However, four months after entry and the spike in out-of-network billing, there was a noticeable drop in out-of-network billing rates. These changes are visible in the raw data, presented hospital by hospital in Appendix Figure 6. In Column (3) of Table 2, we again use an entry regression to identify the effect of TeamHealth entry on hospitals' out-of-network billing. We find that after TeamHealth entered a hospital, there was an increase in out-of-network billing of 32.6 percentage points. This is a qualitatively large increase, although it is still approximately half the size of the out-of-network entry effect that we observed for EmCare. As we illustrate in Appendix Table 3, this estimate is robust to using alternative control groups.

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*5.4. The Impact of Out-of-Network Strategies on Payment Rates*

These results suggest that EmCare does not negotiate with insurers and instead utilizes its outside option and bills its charges. In Panel A of Figure 4, we show that immediately after entry, EmCare raised its charges significantly. In Column (1) of Table 3, we quantify these changes and show that after EmCare entered, it increased its physician charges, on average, by $556.84 (96 percent). This increase in charges was driven, in part, by a 14.8 percentage point (43 percent) increase in the rate that physicians working for the firm billed patients for ED services using the highest-intensity CPT code (Column (7) in Table 3). This increase in the use of high severity coding occurred immediately after the firm entered (Panel G of Figure 4). It is unlikely that hospitals would have experienced a sharp and immediate change in their mix of patients immediately after EmCare entered that would have precipitated such a large change in coding

[22] This result is robust to estimating Equation (13a) using logistic regression.



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practice.[23] Indeed, as we discuss and illustrate in Panels A and B of Appendix Figure 7, there were no immediate and observable changes in the case mix of patients at hospitals after EmCare entered. We have further discussion of the impact of the entry of physician management companies on hospitals' casemix in Section 5.7

As we predicted in Section 4.4, this increase in out-of-network billing and physician charges generated large increases in revenue for EmCare physicians. Likewise, it also exposed patients to increased cost sharing and financial risk. Our data contributor paid most of physicians' out-of-network bills. As a result, after EmCare entered, we observe that the insurer payments to ED physicians increased by $402.67 (122 percent). Because patients typically have out-of-pocket costs that are set via co-insurance that pays a fixed percentage of the total cost of care, patient payments (e.g. cost-sharing payments) to ED physicians increased by $45.23 (83 percent). Collectively, we observe that the total payments to ED physicians increased by $447.90 after EmCare entered a hospital. This is a 117 percent increase in ED physician payments. Notably, these changes occurred immediately after EmCare entered a hospital (Figure 4).



While our data contributor covered most of physicians' out-of-network charges, we still observe a difference between EmCare physicians' charges and the total payments the firm received from the insurer and patients. We classify the difference between physician charges and their total payments as the potential balanced bill patients could face. In our data, we observe that patients' potential balanced bills were, on average, $195.30. We estimate that after EmCare entered a hospital, the potential balanced bill patients faced increased by $108.94 (56 percent). Note that these are lower-bound estimates of the impact of EmCare entry on patients' out-of-pocket costs. In many instances, patients who are treated by out-of-network physicians are liable for the entirety of their physicians' charges, since insurers will not cover out-of-network care. We show in Table 3 that average physician charges were $578.95 across our sample and they nearly doubled, increasing by $556.84 after EmCare entered a hospital. As a result, a patient whose insurer did not cover out-of-network physician care would face a bill from EmCare physicians of, on average, $1,135.79 (= $556.84 + $578.95). Given that nearly half of individuals in the US do not have the liquidity to pay an unexpected $400.00 expense without taking on debt, bills of this magnitude can be financially devastating to a large share of the population (Board of the Governors of the Federal Reserve System 2016).



[23] As we illustrate in Appendix Table 4 and 5, these results are robust when we use alternative control groups.

That TeamHealth exits networks and then rejoins them suggests that the firm exercises the threat of exit to credibly negotiate higher in-network payment rates. Consistent with theory, in Panels B and C of Figure 5, we observe an increase in the in-network and out-of-network payments to TeamHealth from insurers after the firm enters a hospital. In Column (1) of Table 4, we do not observe a precisely estimated increase in charges by physicians after TeamHealth entered a hospital. However, we observe that insurer payments for in-network physician care increased by $236.56 (90 percent) after the firm entered. We also observe a $21.85 (39 percent) increase in patient cost-sharing paid to physicians after TeamHealth entered. While this is a large increase in physician payments, the increase is approximately 60 percent of the size of the gain in physician payments experienced by physicians after EmCare entered a hospital.[24]

In Section 4.4, we posited that having the ability to go out-of-network without seeing a reduction in the number of patients they treat gave ED physicians a stronger outside option in negotiations with insurers. We argued that this stronger outside option would allow them to negotiate higher in-network payments. In Table 5, we show the average in-network payments in our data made to internists for performing standard office visits and orthopedists for performing hip replacement. We observe that, on average, internists are paid 158 percent of Medicare rates (Column (2)) and orthopedists are paid 178 percent of Medicare rates (Column (1)). In contrast, the average in-network ED physician in our data is paid 266 percent of Medicare rates (Column (3)). We posited that firms that credibly threaten to go out-of-network could negotiate higher payments. Indeed, we observe that TeamHealth, who appears to go out-of-network and then rejoin the insurer's network, earn on average, 364 percent of Medicare rates (Column (4)). Likewise, we observe that the average payment in our data to EmCare ED physicians (who, for the most part, do not participate in networks) is 536 percent of Medicare rates (Column (5)).[25]





*5.5 Transfers to Hospitals To Permit Out-of-Network Billing*

We posited that when physicians bill out-of-network, it creates costs for the hospital where they work. In Section 4.3, we hypothesized that physician management firms that used out-of-network billing as a strategy would have to offer transfers to hospitals to offset these costs. These costs could take the form of direct payments or reductions in subsidies (which we cannot

[24] As we illustrate in Appendix Tables 6 and 7, these results are robust to using other control groups.
[25] Appendix Table 8 provides detailed summary statistics of ED physicians' prices and charges.

observe) or changes in physician behavior that benefits hospitals (which we can observe). Our results presented in Table 6 are consistent with our predictions. We estimate Equation (13a) and find that after EmCare entered a hospital and began billing out-of-network for ED services, facility charges at the hospitals where they worked increased by $1,683.63 (27 percent) and facilities' total payments increased by $294.58 (11 percent). As we illustrate in Table 6, this increase in facility payments was driven, in part, by a 1.4 percentage point (5 percent) increase in the probability that a patient received an imaging procedure (Column (5)) and a 2.1 percentage point (23 percent) increase in the likelihood that a patient was admitted to the hospital.[26] As we illustrate in Panel F of Figure 6, this increase in admissions is visible in the raw data and occurred immediately after EmCare entered a hospital.

Because TeamHealth does not remain out-of-network, we would not expect the firm to make transfers to the hospitals where they work. Consistent with these predictions, as we illustrate in Table 7, unlike what we observed following the entry of EmCare, after TeamHealth enters hospitals, we do not observe an increase in facility charges (Column (1)) or total payments (Column (4)). Likewise, we observe that patients treated by TeamHealth physicians after the firm entered a hospital were slightly less likely to have an imaging study and be admitted to the hospital (Columns (5) and (6)). Although facility payments do not increase, as we illustrate in Column (7), we observe a 515.4 person (30 percent) increase in the number of patients treated in the ED after the firm entered a hospital.[27] Notably, these changes in admissions rates and activity are evident immediately after TeamHealth enters a hospital (Panels F and G of Figure 7).





*5.6 Contracting with EmCare and TeamHealth*

Hospitals that knowingly allow an ED staffing company like EmCare to bill out-of-network from their facility in exchange for a transfer (e.g. higher admission rates or a reduction in subsidies to physician groups) are explicitly weighting immediate profits over patient and community benefits. As a result, we would expect that for-profit hospitals to be more likely to contract with EmCare. In Table 8, we present the characteristics of hospitals in our sample that did and did not contract with EmCare and TeamHealth. We find that across all hospitals that meet our sample restrictions, 66 percent are non-profit, 19 percent are for-profit, and 15 percent are government

[26] As we illustrate in Appendix Tables 9 and 10, these results are robust against other control groups.
[27] As we illustrate in Appendix Tables 11 and 12, these results are robust against other control groups.

owned. Consistent with our predictions, 56 percent of hospitals where EmCare has a contract are for-profit. Hospitals in areas with lower numbers of physicians per capita are also more likely to contract with EmCare. In contrast, whereas TeamHealth has a higher share of for-profit hospitals than we observe across the universe of hospitals in our data, the majority of TeamHealth contracts occur at non-profit hospitals.[28]

*5.7 Robustness Checks*

It is possible that the entry of EmCare and TeamHealth led to subsequent changes in the case mix of patients that the hospitals treat. Indeed, both EmCare and TeamHealth advertise that a benefit of their service is to shorten ED waiting times (Cantlupe 2013). With shorter waiting times, hospitals could potentially attract healthier patients who would have otherwise received treatment at urgent care centers. Likewise, on EmCare's webpage, EmCare has highlighted its excellence in improving the treatment of complex cases, such as stroke care (EmCare 2014). To the extent that this improves a hospital's reputation, advertising and improvements in quality could allow that hospital to attract more complex patients. Any changes in the case mix of hospitals EmCare entered could explain why, after the firm entered hospitals, the rates of hospital admissions, the rates of imaging tests, and the rates at which physicians coded for the most intensive services increased.

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In Appendix Table 15, we analyze the impact that the entry of EmCare and TeamHealth had on the case mix of patients that hospitals treat. We find evidence that after EmCare entered a hospital, the hospital attracted a sicker mix of patients. In Columns 1 and 2, we show that after EmCare entered a hospital, the six-month historical spending of the hospital's patients increased by $916.02 (15 percent) and the 12-month historical spending increased by $1,306.16 (11 percent). We also find that after the entry of EmCare into a hospital, the patients who attend the ED were 3.3 percentage points more likely to have a non-zero Charlson comorbidity score measured using six months of patient history and 3.6 percent more likely to have a non-zero Charlson comorbidity score measured using 12 months of patient history. In contrast, following the entry of TeamHealth, hospitals attracted seemingly healthier patients who spent $336.35 (5.4

[28] In Appendix Table 13, we present conditional correlates of whether a hospital is managed by either EmCare or TeamHealth using logistic regression. These results are qualitatively similar to the above. As we show in Appendix Table 14, hospitals that contract with EmCare or TeamHealth before 2011 have similar characteristics to hospitals where we observe the entry of EmCare or TeamHealth between 2011 and 2014.



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