



## **Michael D. Roth, Esq.**

### ***Sample ADR Healthcare Cases***

*See below brief description of representative healthcare cases at which Mr. Roth has served as the arbitrator or mediator.*

- Claim by a cardiology group for payment of fair market value (“FMV”) in an amount of over \$11,300,000 for operating the cardiac catheterization laboratories at two hospitals pursuant to an “under arrangement” contract it had with the hospitals. Primary issues included calculation of FMV and whether the hospitals breached the contract by prematurely terminating such contract with the group.
- A hospital claim against a health plan that it was entitled to payment of its billed charges in an amount of over \$275,000 (plus interest pursuant to California Health and Safety (“H&S”) Code §1371) based upon its having provided non-contract emergency care services to over 120 patients. Primary issues included: (i) calculating amounts due under H&S Code §1371.4(b) and 28 California Code of Regulations §1300.71(a)(3)(B), and (ii) to what extent the patients were members of the health plan.
- A contract claim by a hospital seeking to obtain payment in an amount of more than \$800,000 from a health plan for services that the hospital provided to a beneficiary for whom the plan and/or plan-affiliated IPA were alleged to be responsible. Hospital claimed that the plan and IPA violated California Business and Professions Code §17200 by engaging in conduct intended to stymie or delay payments.
- A breach of contract claim by a hospital against a health plan based upon the plan’s failure to list the hospital in the plan’s on-line and print directories in accordance with the contract between them. Primary issues included whether: (i) the plan materially breached the contract, (ii) the hospital was entitled to be compensated as a non-contract provider, and (iii) the hospital was entitled to lost profits.
- A contract claim by a provider of therapy services sought to obtain payment in an amount of over \$700,000 from a skilled nursing facility (“SNF”) for services that the therapy provider furnished to the SNF’s patients. Issues included whether: (i) contract claims were waived, and (ii) the claimant failed to mitigate its damages.
- A medical billing service (claimant) sought payment from a physician practice for billing services which it furnished on behalf of the physician. Primary issues included whether claimant miscoded claims and failed to timely submit claims.

- A specialty medical group sought payment from an IPA in the approximate amount of \$63,000 for services furnished to patients for whom the IPA was alleged to be responsible. Primary issues included whether: (i) the patients listed in the group's accounts receivable were enrollees of the IPA, and (ii) the IPA was otherwise responsible for these patients.
- Claim by a licensed dental health plan for refund of a payment which it made to one of its in-plan dentists based upon the dentist's failure to employ standard diagnostic and treatment protocols for a specific patient in accordance with the applicable standard of care. At issue was whether the dentist met the standard of care in treatment of the patient.
- Claim by a hospital that a payor failed to reimburse the hospital in accordance with the payor's HMO/ PPO contracted rates in connection with services furnished by the hospital to the payor's members/insureds. Issues included: (i) level of care, (ii) medical necessity, (iii) stop-loss calculations, and (iv) financial responsibility of a related IPA.