Medicare/Medicaid Reimbursement

Clients throughout the healthcare industry and professions rely on our analysis, strategizing, advice, negotiation, and – where necessary – litigation of Medicare and Medicaid reimbursement matters. This can typically involve:

- **Asserting or resisting claims, audits, disallowances, recoupments, and administrative proceedings (including appeals before the HHS Provider Reimbursement Review Board) as well as in State and Federal court**
- **Opposing burdensome or improper State regulatory provisions or other unauthorized administrative action**
- **Conducting or supervising internal investigations of provider billing practices to determine compliance with applicable requirements, including "overpayment" self-disclosure requirements under the so-called "60 day" rule**
- **Giving informed counsel on innovative reimbursement methodologies including bundled payment programs, ACOs, and other healthcare initiatives, based on our close monitoring of legal reforms and reimbursement changes that are driving clinical integration initiatives across the country**
- **Third-party payor coverage issues**
- **Complex or unusual issues as to Medicare and Medicaid managed care, Disproportionate Share Hospitals, Upper Payment Limits, and others**
- **Billing disputes on a wide variety of legal and factual grounds**
- **Defending against or negotiating settlements of False Claims Act (FCA) claims and *qui tam* litigations**

Reimbursement advice and dispute resolution built on experience and longstanding relationships

Our decades of experience in the healthcare world, combined with strong working relationships with the state and federal Medicaid and Medicare agencies, often allows us to resolve reimbursement issues before they become disputes. We can often obtain clarification on issues of concern that may not be clear on the face of published regulations and guidance.

We believe there is an essential connection between healthcare FCA litigation and a command of state and federal healthcare fraud and abuse and reimbursement laws – laws that one appellate court has described as "almost unintelligible to the uninitiated." Our deep Medicare and Medicaid experience explains why major providers have retained Katten to handle their threatened or pending Medicare- and Medicaid-related FCA matters. Our core healthcare team includes former Assistant US Attorneys with many years of healthcare litigation experience. And our FCA matters have involved diverse allegations such as duplicate billing, billing for medically unnecessary services, billing for services by unlicensed providers, and violations of the Stark Act and anti-kickback statute. We have also handled FCA allegations involving highly technical issues such as provider billing for physician services in teaching hospitals, school-based healthcare services, early intervention services, and personal care services in violation of applicable requirements.

In addition, we regularly assist clients with facility licensing and Form 855 preparation. Our attorneys help new providers enroll in the Medicare and Medicaid programs and existing providers complete change of information filings in accordance with CMS requirements. We also work with health system, private equity, and national ancillary care providers to address facility licensing and Medicare/Medicaid enrollment issues in connection with mergers, acquisitions, joint ventures, and other change-of-ownership situations.

Our clients include

- Hospitals and academic medical centers
- Ambulatory surgical centers
- Diagnostic and treatment centers and FQHCs
- Nursing homes and hospices
- Provider associations
- Physicians and physician groups
- Rehabilitation agencies
- Comprehensive outpatient rehabilitation facilities
- Home health agencies
- Dialysis companies

- Imaging centers
- Clinical laboratories and durable medical equipment suppliers
- Pharmacies
- Hospital management companies
- Emergency ambulance services
- Third-party billing services
- 340B entities

Our Experience

- Defended large healthcare provider in False Claims Act litigation. Government alleged submission of false claims to the Medicaid program for early intervention services to developmentally delayed children. Court granted in part our motion to dismiss.
- Defended major US municipality and public hospital system in a federal False Claims Act *qui tam* litigation brought by a whistleblower, alleging the submission of false Medicaid claims for hospital, long-term care and other services.
- Advise large healthcare system on complex federal and state regulations governing supplemental Medicaid payments, such as Disproportionate Share Hospital, Upper Payment Limit payments and value-based payments under a federal waiver program.
- Represent large healthcare system in prosecution and settlement of hundreds of Medicare appeals before the Provider Reimbursement Review Board.
- Represent large healthcare system in opposing numerous government audits and investigations, including negotiating settlements of threatened recoupment of Medicare and Medicaid payments.
- Counseled major healthcare system's long-term home healthcare program in challenging a threatened recoupment by the New York State Office of the Medicaid Inspector General of millions of dollars' worth of Medicaid payments. We negotiated a settlement of less than one percent of the initial audit finding.
- Counsel large healthcare system in establishing and operating an Accountable Care Organization, including assistance in applying for participation in the Medicare Shared Savings Program and applying for designation by the New York State Department of Health as an Accountable Care Organization.
- Represent large healthcare system and physician group as defendants in *qui tam* False Claims Act case before the US District Court for the Eastern District of New York alleging submission of

false Medicare and Medicaid claims for podiatry services and for medical education reimbursement.

- Represent public hospital in trial against the New York State Office of the Medicaid Inspector General. Involves novel issues of what services provided to undocumented aliens are reimbursable under Medicaid.
- Assist hospital trade association and its members. Services include preparing legal challenges to State Medicaid budget cuts; assisting in developing programs to expand health insurance coverage; and advising on matters involving Medicare and Medicaid reimbursement, fraud and abuse, intergovernmental transfers, Medicaid State Plan Amendments, provider taxes and payment limitations, and Medicare graduate medical education payments.
- Represent hospital in a civil investigation being conducted by the US Attorney's Office for the Eastern District of New York involving novel issues of Medicaid coverage of services furnished to certain categories of patients.
- Assist hospital system in converting its freestanding clinics to FQHCs.
- Advise large hospital system in purchasing drugs under 340B discount program, and related 340B compliance issues.
- Represent managed care organization in seeking recovery of overpayments made to healthcare provider.
- Advise organization concerning application of corporate practice of medicine doctrine, fee-splitting prohibitions, scope of practice restrictions and health facility co-location issues.
- Primary outside counsel to large healthcare system in various matters. We defend client in suspected Medicare/Medicaid fraud and False Claims Act investigations, assist regarding supplemental Medicaid payments, oppose government audits, and created and implemented a corporate-wide compliance program. We also helped effect a major reorganization of affiliate relationships; prosecute Medicare appeals; and counsel on HIPAA and healthcare privacy matters, provision of health services in correctional facilities, and a threatened suit against the State regarding Medicaid payments.
- Counsel to large municipal school district in obtaining dismissal of *qui tam* case alleging violations of the False Claims Act in connection with the school district's Medicaid claims for case management services. The case is on appeal before the US Court of Appeals for the Second Circuit.
- Represent large municipal health system in a suit filed against the federal Medicare agency alleging an illegal and arbitrary cap on reimbursement cost apportionment.

- Advised hospital management firm in settling allegations that it breached the False Claims Act by aiding the inappropriate admissions of patients for hospital services. Our client did not admit any wrongdoing and is one of several defendants in New York federal litigation dating back to 2002.

Recognitions

Recognized or listed in the following:

- *Best Law Firms*
  - Health Care Law
    - National, 2013–2026
    - Chicago, 2011–2026
    - Dallas/Ft. Worth, 2020–2026
    - New York, 2011–2024
- *Chambers USA*
  - Healthcare: The Elite
    - Nationwide, 2026
  - Healthcare: Highly Regarded
    - Nationwide, 2021–2025
  - Healthcare
    - Illinois, 2006–2026
    - New York, 2006–2025
    - Texas, 2019–2026
  - Litigation: White–Collar Crime and Government Investigations
    - Illinois, 2007–2026
    - Texas, 2022–2026
  - Litigation: White-Collar Crime & Government Investigations: Highly Regarded
    - New York, 2021–2026
- *The Legal 500 United States*
  - Healthcare
    - Service Providers, 2016–2026