



CASE STUDY: HEALTH PLAN CLIENT

Provider group alleges large Health Plan underpayments; however, Fountainhead's objective analysis reveals net overpayments.

A Health Plan contracted with an independent practice association (“IPA”) to pay claims that the IPA submitted on behalf of its member physicians. The contract specified that the Health Plan would pay claims at a certain percentage of the Medicare fee schedule. The IPA would then retain a percentage of the payment for each claim, and pay the residual to the provider that submitted the claim. The contract was in force for four years and terminated per the terms of the contract. Following termination, the IPA sued the Health Plan for breach of contract. Among the causes of action were failure to pay claims in a timely manner, inappropriate denials, and underpaid claims.

Fountainhead was engaged by outside counsel for the Health Plan to collect, manage and analyze all of the data related to these transactions. Fountainhead performed several functions related to this matter; they are described in further detail below:

Collect Information

This phase required us to develop an understanding of the processes used by the Health Plan. Fountainhead performed on-site interviews of Health Plan personnel to understand and document the claims process. Fountainhead also identified the data and documents that were created as a result of, or in support of, these transactions. We requested extracts of the electronic data from the claims and payment system and the provider credentialing system. Further, we collected provider-specific information from hard copy documents, including the date upon which each provider signed the contract to join the IPA. We also had the opportunity to interview personnel from the IPA and make a formal discovery request for their data. We loaded all of these data into a series of relational database tables, taking exceptional steps to ensure and secure data integrity and accuracy throughout the litigation process.

Manage and Produce

All of the data provided to Fountainhead in this matter were discoverable and extracted from the databases as necessary during the litigation. Our client looked to us to manage the process of producing these data extracts to opposing counsel. Each time additional data were provided by the Health Plan, Fountainhead would identify and compile the new information and provide it to counsel for production.

Report

The overarching objective of this phase was to provide objective analyses to our client to allow them to understand how the Health Plan had conducted its business. This phase involved several different projects. First, counsel for the Health Plan requested extensive reports for each provider in the IPA. The IPA consisted of more than 1,200 providers, all



of whom submitted claims during the four-year contract period. In total, there were approximately one million claim lines submitted to the Health Plan for payment. Fountainhead's reports identified how each provider submitted his or her bills, whether it was through the IPA or to the Health Plan directly. This was a key point in the litigation because the IPA had alleged that they had an exclusive agreement with the Health Plan that required their providers to bill through the IPA. A close analysis by Fountainhead of the claims data revealed that this, in fact, was not the case. Further, upon reviewing the provider credentialing data, we determined that close to half of the providers were not "par" with the Health Plan, revealing an area where the IPA had breached its agreement with the Health Plan. We generated and provided these reports to counsel for the Health Plan, some numbering in the tens of thousands of pages.

Analyze

Fountainhead performed several different complex analyses using the data provided. These analyses were intended to determine if there was any substance to the allegations set forth in the complaint. For example, one in-depth objective analysis that we performed was a claim "re-pricing" analysis. As mentioned above, the contract stated that the claims were to be paid at a certain percentage of the Medicare fee schedule. The Health Plan provided the fee schedules in electronic format for the contract period and we loaded them into our proprietary data model. We then "re-priced" each claim, on a claim-line basis, at the appropriate fee schedule amount. In the complaint, the IPA alleged that the Health Plan had underpaid them by more than \$30 million. After re-pricing each claim line that had been submitted for payment to reflect the correct amount, Fountainhead revealed that the Health Plan had overpaid the IPA by close to \$500,000.