



CASE STUDY: RECONCILIATION OF MEDICARE CLAIMS

An HMO suspected that it was overpaid by CMS and requested a detailed, objective analysis to quantify such payments. As a byproduct of this investigation, Fountainhead's analysis also identified specific claims that CMS never received and/or paid.

A Health Maintenance Organization (“HMO”) suspected that it had been overpaid on claims submitted to the Centers for Medicare & Medicaid Services (“CMS”) via its third-party billing agent (“billing agent”). In-house counsel for the HMO engaged Fountainhead to perform an objective analysis of these claims in two phases. Phase I identified those payments made by CMS for which the HMO had not submitted a corresponding claim via its billing agent. Phase II identified claims for which a payment had not been received from CMS, if any.

Fountainhead performed several steps during this process; they are summarized below:

Collect Information

Prior to beginning work on Phase I, Fountainhead developed a thorough understanding of the claims processes used by the HMO and its billing agent. Fountainhead interviewed key personnel from both the HMO and the billing agent to understand and document the entire claims process. Fountainhead also identified the data and documents that were created as a result of, or in support of, these transactions. We discovered that there were three data sources in which a record of these transactions would appear, if claims were properly received and paid. First, the claim would appear in the HMO's billing system. Second, the claim would appear in the billing agent's billing system after the claim was transmitted from the HMO to the billing agent, coded and sent to CMS. Third, the claim would appear in the electronic remittance notice (“ERN”) that CMS sent to the billing agent and to the HMO. We requested and obtained extracts of the electronic data from these data sources to use in our analysis.

Convert Data to Usable Format

Two of the data sources were obtained in the “native” format in which they were either sent to or received from CMS. At first view, these data appeared to be unusable. However, Fountainhead was able to convert these largely indecipherable data files into readable “rows and columns” for further analysis. Simultaneously, Fountainhead developed quality assurance methods to verify that the native data had not been modified or lost during the conversion process.

Phase I: Identify claims for which the HMO did not bill

Phase I was designed to identify those claims that CMS had paid but for which the HMO had not submitted a corresponding claim during the timeframe in question. These payments constituted overpayments by CMS and would need to be quantified and returned to CMS via self-disclosure. These claims appeared on the ERNs from CMS but



did not appear on the HMO claims data files. Using the data extracts mentioned above, Fountainhead performed a detailed, claim-line level analysis on all claims from the relevant time period. Subsequently, Fountainhead verified that, indeed, there were payments received from CMS for which a corresponding claim could not be located in the HMO's claims data.

Phase II: Identify unpaid claims

Phase II was designed to identify those claims submitted by the HMO to CMS that were never paid by CMS. It was unknown at the outset of the engagement whether there would be any such claims; however, our thorough claim-line level approach enabled us to determine whether such claims existed and to identify them discretely. After excluding all denied claim lines, we determined that such claims did exist and that they fell into two categories. First, there were claims made up of multiple claim lines for which CMS did not pay all of the claim lines. Second, there were claims for which the HMO billed that did not appear at all on the CMS ERNs. Fountainhead identified these claims in a report provided to the HMO, allowing them to review and resubmit these claims to CMS for payment.