**CASE NO. 85525; *Combined with* CASE NO. 85656**

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IN THE SUPREME COURT OF NEVADA

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UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTHCARE SERVICES, INC. D/B/A UNITEDHEALTHCARE; UMR, INC. D/B/A UNITED MEDICAL RESOURCES; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.; AND HEALTH PLAN OF NEVADA, INC.,

*Appellants*,

vs.

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C.; AND CRUM STEFANKO AND JONES, LTD., D/B/A RUBY CREST EMERGENCY MEDICINE.

*Respondents*.

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Appeal from the Eighth Judicial District Court, Clark County
District Court Case No. A-19-792978
Hon. Nancy L. Allf, District Judge

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# APPENDIX OF EXHIBITS TO RESPONDENTS' ANSWERING BRIEF

## VOLUME 12 OF 13

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**APPENDIX OF EXHIBITS TO RESPONDENTS' ANSWERING BRIEF**

**VOLUME 12 OF 13**

**TABLE OF CONTENTS**

# INDEX

| | | | | |
|---|---|---|---|---|
| | | Production of Documents and Answers to Interrogatories on Order Shortening Time | | |
| 6 | 11/9/2020 | Notice of Entry of 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 Time | 1 | RA000131-RA000141 |
| 10 | 7/1/2021 | Order Denying Petition | 1 | RA000239-RA000243 |
| 3 | 8/25/2020 | Petition for Writ of Prohibition, Or, Alternatively, Mandamus | 1 | RA000032-RA000106 |
| 11 | 9/30/2021 | Plaintiffs' Motion for Further Sanctions Against Defendants for Failure to Produce Documents in Accord with August 3, 2021 Order on Order Shortening Time - **FILED UNDER SEAL** | 2 | RA000244-RA000267 |
| 15 | 2/9/2022 | Plaintiffs' Status Report and Response to United's and Multiplan's Submissions for February 10, 2022 Hearing | 2 | RA000345-RA000357 |
| 16 | | Trial Exhibit DX5177 | 2 | RA000358-RA000373 |
| 17 | | Trial Exhibit PX010 - **FILED UNDER SEAL** | 3 | RA000374-RA000496 |
| 18 | | Trial Exhibit PX012 | 4 | RA000497-RA000502 |
| 19 | | Trial Exhibit PX014 | 4 | RA000503-RA000515 |
| 20 | | Trial Exhibit PX025 - **FILED UNDER SEAL** | 4 | RA000516-RA000518 |
| 21 | | Trial Exhibit PX031 | 4 | RA000519 |
| 22 | | Trial Exhibit PX032 | 4 | RA000520-RA000522 |
| 23 | | Trial Exhibit PX033 | 4 | RA000523-RA000525 |
| 24 | | Trial Exhibit PX034 - **FILED UNDER** | 4 | RA000526- |

| | | | | |
|---|---|---|---|---|
| | | **SEAL** | | RA000535 |
| 25 | | Trial Exhibit PX035 | 4 | RA000536-RA000537 |
| 26 | | Trial Exhibit PX037 | 4 | RA000538-RA000539 |
| 27 | | Trial Exhibit PX043 | 4 | RA000540-RA000541 |
| 28 | | Trial Exhibit PX053 - **FILED UNDER SEAL** | 4 | RA000542-RA000553 |
| 29 | | Trial Exhibit PX055 | 4 | RA000554-RA000555 |
| 30 | | Trial Exhibit PX061 | 5 | RA000556-RA000722 |
| 31 | | Trial Exhibit PX066 - **FILED UNDER SEAL** | 5 | RA000723-RA000754 |
| 32 | | Trial Exhibit PX079 | 5 | RA000755-RA000760 |
| 33 | | Trial Exhibit PX085 | 5 | RA000761-RA000769 |
| 34 | | Trial Exhibit PX092 - **FILED UNDER SEAL** | 5 | RA000770-RA000795 |
| 35 | | Trial Exhibit PX100 | 5 | RA000796-RA000798 |
| 36 | | Trial Exhibit PX120 | 6 | RA000799-RA001036 |
| 37 | | Trial Exhibit PX163 | 7 | RA001037-RA001204 |
| 38 | | Trial Exhibit PX165 – Part 1 of 2 | 8 | RA001205-RA001455 |
| 38 | | Trial Exhibit PX165 – Part 2 of 2 | 9 | RA001456-RA001492 |
| 39 | | Trial Exhibit PX168 – Part 1 of 2 | 9 | RA001493-RA001700 |
| 39 | | Trial Exhibit PX168 – Part 1 of 2 | 10 | RA001701-RA001763 |
| 40 | | Trial Exhibit PX243 - **FILED UNDER SEAL** | 10 | RA001764 |
| 41 | | Trial Exhibit PX246 - **FILED UNDER SEAL** | 10 | RA001765-RA001775 |

| | | | | |
|---|---|---|---|---|
| 42 | | Trial Exhibit PX256 - **FILED UNDER SEAL** | 10 | RA001776-RA001777 |
| 43 | | Trial Exhibit PX288 - **FILED UNDER SEAL** | 11 | RA001778-RA001984 |
| 44 | | Trial Exhibit PX293 | 11 | RA001985-RA001987 |
| 45 | | Trial Exhibit PX297A - **FILED UNDER SEAL** | 11 | RA001988 |
| 46 | | Trial Exhibit PX314 - **FILED UNDER SEAL** | 11 | RA001989-RA001992 |
| 47 | | Trial Exhibit PX342 - **FILED UNDER SEAL** | 12 | RA001993-RA002035 |
| 48 | | Trial Exhibit PX363 | 12 | RA002036-RA002042 |
| 49 | | Trial Exhibit PX368 - **FILED UNDER SEAL** | 12 | RA002043-RA002054 |
| 50 | | Trial Exhibit PX370 - **FILED UNDER SEAL** | 12 | RA002055-RA002058 |
| 51 | | Trial Exhibit PX375 - **FILED UNDER SEAL** | 12 | RA002059-RA002062 |
| 52 | | Trial Exhibit PX424 | 12 | RA002063-RA002065 |
| 53 | | Trial Exhibit PX426 - **FILED UNDER SEAL** | 12 | RA002066-RA002184 |
| 54 | | Trial Exhibit PX444 - **FILED UNDER SEAL** | 12 | RA002185-RA002189 |
| 55 | | Trial Exhibit PX447 - **FILED UNDER SEAL** | 12 | RA002190-RA002216 |
| 56 | | Trial Exhibit PX462 - **FILED UNDER SEAL** | 13 | RA002217-RA002250 |
| 57 | | Trial Exhibit PX472 - **FILED UNDER SEAL** | 13 | RA002251 |
| 58 | | Trial Exhibit PX473 - **FILED UNDER SEAL** | 13 | RA002252-RA002365 |
| 59 | | Trial Exhibit PX473B | 13 | RA002366 |
| 60 | | Trial Exhibit PX473G | 13 | RA002367 |
| 61 | | Trial Exhibit PX477 - **FILED UNDER SEAL** | 13 | RA002368-RA002372 |
| 62 | | Trial Exhibit PX478 | 13 | RA002373- |

| | | | | |
|---|---|---|---|---|
| | | | | RA002388 |
| 63 | | Trial Exhibit PX506 | 13 | RA002389-RA002392 |
| 64 | | Trial Exhibit PX512 - **FILED UNDER SEAL** | 13 | RA002397 |
| 7 | 12/7/2020 | UnitedHealth Group, Inc.'s Responses to Plaintiffs' First Set of Requests for Production of Documents | 1 | RA000142-RA000164 |

## CERTIFICATE OF SERVICE

I certify that I am an employee of BAILEY❖KENNEDY and that on the 28th day of August, 2023, service of the foregoing **Appendix of Exhibits to Respondents' Answering Brief – Volume 12 of 13** was made by electronic service through Nevada Supreme Court's electronic filing system and/or by depositing a true and correct copy in the U.S. Mail, first class postage prepaid, and addressed to the following at their last known address:

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*/s/ Karen Rodman*
Employee of BAILEY❖KENNEDY

# EXHIBIT 47

# EXHIBIT 47

# FILED UNDER SEAL PURSUANT TO PENDING MOTION TO SEAL FILED CONCURRENTLY HEREWITH

# EXHIBIT 48

# EXHIBIT 48

# Information on Payment of Out-of-Network Benefits

Certain health care benefit plans administered or insured by affiliates of UnitedHealth Group Incorporated provide "out of-network" medical and surgical benefits for members. With out of-network benefits, members may be entitled to payment for covered expenses if they use doctors and other health care professionals outside of the UnitedHealthcare network. The member or health care professional, depending on whether or not the member has assigned his or her claim, may send a claim for such out of network professional services to be paid by a UnitedHealth Group affiliate. The UnitedHealth Group affiliate will pay based on the terms of the member's health care benefit plan that in many cases provides for payment for amounts that are the lower of either:

- the out of-network provider's actual charge billed to the member, or
- "the reasonable and customary amount," "the usual, customary, and reasonable amount," "the prevailing rate," or other similar terms that base payment on what other healthcare professionals in a geographic area charge for their services.

## What Do These Terms Mean?

The terms "the reasonable and customary amount," "the usual, customary, and reasonable amount," and "the prevailing rate" are among the standards that various health care benefit plans may use to pay out of network benefits. Such plans determine the amounts payable under these standards by reference to various available resources. These resources contain information on the charges or costs for professional services or supplies. The resource used for payment of professional services is based on what other health care professionals in the relevant geographic areas or regions charge for their services.

These standards do not apply to plans where reimbursement is determined using Medicare rates. Further, UnitedHealth affiliates use different resources in applying these standards with respect to services provided by facilities such as general hospitals or ambulatory surgical centers or in determining the reimbursement for pharmaceutical products (as further discussed below). Also, a member's health care benefit plan may define these standards differently or contain additional standards, and it is the language of the member's health care benefit plan or the plan's interpretation of such language that is controlling. Therefore, a member should always consult his or her health care benefit plan when assessing how much he or she may be reimbursed for out of-network benefits.

## How Does This Affect Members?

If a health care benefit plan requires payment using the term "reasonable and customary" or similar language mentioned above with respect to medical and surgical procedures performed and billed by

Plaintiffs' Exhibit
PX 363



FESM000335

RA002036 363.001

health care professionals or health care professional group practices, then the affiliates of UnitedHealth Group most commonly refer to a schedule of charges created by FAIR Health, Inc. ("FAIR Health") to determine the amount of the payment.

## What is FAIR Health?

FAIR Health provides health care consumers with an estimate of how much out-of-network services will cost them. Health care consumers can access **FAIR Health's Consumer Price Lookup**.

Additionally, FAIR Health publishes two Benchmark data products called the FH Benchmark Database and the FH RV Benchmark Database. The information in these FAIR Health Benchmark databases is updated and published by FAIR Health at scheduled times each year. UnitedHealth Group affiliates which administer health care plans based on the term "reasonable and customary" or similar standards use the medical/surgical module of one of these FAIR Health Benchmark Databases to determine the maximum amount they will pay for reimbursement of professional fees for medical and surgical services. By using the schedule of charges in the medical/surgical module of these FAIR Health Benchmark databases, the maximum amount a UnitedHealth Group affiliate will pay to members will, at times, be less than the amount billed for particular professional services. Use of this maximum amount then affects the members' "out-of-pocket" cost they must pay to out-of-network health care professionals, under the terms of many health care benefit plans, members are responsible for the difference between the professionals' charges and what the UnitedHealth Group affiliate pays.

## How are the FAIR Health Databases Used For Out-of-Network Payments?

Various health insurers and plan administrators periodically send FAIR Health data about claims for services of health care professionals. The claims include the date and the place of the service, the procedure code, and the provider's charge. FAIR Health combines this information into databases that show how much health care professionals have charged for nearly all services in defined geographic areas in the United States. FAIR Health creates and publishes two Benchmark Databases named the FH Benchmark Database and the FH RV Benchmark Database. Depending on the applicable health care plan, UnitedHealth Group affiliates may use one of these databases as a resource for determination of reimbursement amounts for out-of-network services of health care professionals.

The following example illustrates the information gathered by FAIR Health in the FH Benchmark Database: FAIR Health receives charge information of health care professionals who perform colonoscopies in a particular geographic area for a particular time period. The charges of these health care professionals for colonoscopies are arranged from low to high and then percentiles are identified from that arrangement. Here is a simplified illustration of a percentile chart for a colonoscopy for one geographic area:

| CPT Code | Description | 50th | 60th | 70th | 75th | 80th | 85th | 90th | 95th |
|---|---|---|---|---|---|---|---|---|---|
| 45378 | COLONOSCOPY | $764 | $783 | $859 | $887 | $907 | $939 | $1008 | $1105 |

Affiliates of UnitedHealth Group frequently use the 80th percentile of the FAIR Health Benchmark Databases to calculate how much to pay for out-of-network services of health care professionals, but plan designers and administrators of particular health care benefit plans may choose different percentiles for use with applicable health care benefit plans. Members may contact the customer service line of the applicable UnitedHealth Group affiliate shown on the back of the member's health identification card to learn of the percentile applicable to the member's health plan.

Health care benefit plans managed by UnitedHealth Group affiliates began to use FAIR Health's Benchmarking Databases to determine payment for out-of-network professional services within 60 days of first receiving the applicable FAIR Health Benchmark Database Modules at various times in 2011.

For additional information regarding the FAIR Health Benchmark Databases, please visit **FAIR Health's website**.

## Important Exclusions

UnitedHealth Group affiliates will not use the FAIR Health Benchmarking Databases to determine out of network benefits for professional services if a member's health care benefits plan does not require payment under standards such as "the reasonable and customary amount," "the usual, customary, and reasonable amount," "the prevailing rate" or similar terms. For example, if a member's plan provides for payment based upon Medicare rates, UnitedHealth Group affiliates will not use the FAIR Health Benchmarking Databases as a resource for determining payment amounts.

## Reimbursement Policies

UnitedHealth affiliates may apply certain payment policies that can affect both the amount they pay for such benefits and a member's out-of-pocket costs. For example, the Multiple Procedure Policy applies when multiple procedures are performed on the same day by the same healthcare professional. Under this policy, coverage for the primary/major procedure is 100% of the allowable amount, and 50% of the allowable amount for the secondary procedure. Coverage for all subsequent procedures is 25 or 50% of the allowable amount, depending on a member's health plan. This accounts for the fact that many medical and surgical services include pre procedure and post procedure work, as well as generic services integral to the standard medical/surgical service (like recording preoperative, intraoperative, and postoperative documentation) that would be performed for the primary procedure and not duplicated for additional procedures. See descriptions of the **Multiple Procedure Policy and other payment policies.**

## Physician Administered Pharmaceuticals

UnitedHealth Group affiliates consider pharmaceutical products administered and billed by health care professionals or health care provider groups to be professional services or supplies for purposes of claims reimbursement when such drugs are covered under a member's health plan. UnitedHealth Group affiliates generally deem the Average Wholesale Price ("AWP") for such pharmaceutical products to be an amount which satisfies plan standards such as "reasonable and customary" or similar standards mentioned above, and thus use AWP to determine out of network reimbursement for such products.

The AWP values considered by UnitedHealth Group affiliates are provided by a comprehensive database covering virtually every drug product approved by the Food and Drug Administration for manufacture and distribution. This database is developed and maintained by an independent vendor, Thomson Reuters, and is collected from over 1,200 pharmaceutical manufacturers and distributors.

UnitedHealth Group affiliates reimburse for pharmaceutical products administered and billed by health care professionals or health care provider groups by reference to AWP for a number of reasons. AWP is an industry standard of reimbursement and is widely accepted by health care professionals, governments, and managed care companies as appropriate payment for such products. In addition, government studies demonstrate that reimbursement at AWP typically is significantly higher than actual prices paid by health care professionals for pharmaceutical products. Finally, the prices paid by health care professionals for these products do not vary across geographic regions to the degree that charges for professional services vary across geographic regions, which makes a national standard on reimbursement for these products more appropriate and more consistent with the plan standards mentioned above.

## Glossary

**Allowable amount –** as used in circumstances covered by this notice, the dollar amount eligible for reimbursement with respect to a claim for out-of-network benefits. The standard for determining the allowed amount can vary by health plan, and may be based (depending upon the language of a member's health plan) upon the lower of either the provider's charge or the "reasonable and customary amount," as explained in the beginning of this notice. This dollar amount may not be the amount ultimately paid to the member or provider as it may be reduced by any co-insurance or deductible that is owed by the member.

**AWP (Average Wholesale Price) –** the Average Wholesale Price for pharmaceutical products which UnitedHealth Group affiliates determine based on a comprehensive database developed and maintained by Thomson Reuters.

**CPT codes –** a set of codes and descriptions of services and procedures performed by physicians and other health care professionals. Each service and procedure is identified by its own five-digit code. Physicians and other health care professionals use CPT codes in making claims for payment. CPT codes are maintained by the American Medical Association.

**FAIR Health –** a not-for-profit organization selected by the Attorney General of the State of New York ("NYAG") to provide the health care consumer with data associated with out-of network services.
**FH Benchmarking Database –** one of two compilations of information on health care professional charges created by FAIR Health and used by affiliates of UnitedHealth Group to determine payment for out-of-network professional services when reimbursed under standards such as "the reasonable and customary amount," "the usual, customary, and reasonable amount," "the prevailing rate," or other similar terms that base payment on what other healthcare professionals in a geographic area charge for their services.

**FH RV Benchmarking Database –** one of two compilations of information on health care professional charges created by FAIR Health and used by affiliates of UnitedHealth Group to determine payment for out of-network professional services when reimbursed under standards such as "the reasonable and customary amount," "the usual, customary, and reasonable amount," "the prevailing rate," or other similar terms that base payment on what other healthcare professionals in a geographic area charge for their services.

**Out-of-network benefits –** benefits provided under a health care benefits plan for services or supplies provided by doctors and other health care professionals who are not parties to a contract with a UnitedHealth Group affiliate.

**Out-of-pocket cost –** portion of the cost of health services that the plan member must pay, including the difference between the amount charged by an out-of-network provider and what a UnitedHealth Group affiliate pays for such services.

**Prevailing Healthcare Charges System database ("PHCS Database")** – one of two compilations of information on health care professional charges created by Ingenix, Inc., now known as Optum Insight, Inc., a wholly owned subsidiary of UnitedHealth Group. UnitedHealth Group affiliates no longer use the PHCS database for determining reimbursement.

**Professional Services** – Health care services provided, and billed for, by professionals such as physicians, psychologists, behavioral and health therapists and other practitioners. It does not include health care services for which facilities, such as hospitals or other health care centers, seek reimbursement.

**Provider network** – doctors and other health care professionals who agree to provide medical care to our members under the terms of a contract.

**UnitedHealth Group** – UnitedHealth Group (NYSE: UNH) is a diversified health and well being company dedicated to making health care work better. Headquartered in Minneapolis, Minn., UnitedHealth Group offers a broad spectrum of products and services through UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State, OptumHealth, Optum Insight and Prescription Solutions. Through this family of businesses, UnitedHealth Group affiliates serve more than 70 million individuals nationwide.

# EXHIBIT 49

# EXHIBIT 49

# FILED UNDER SEAL PURSUANT TO PENDING MOTION TO SEAL FILED CONCURRENTLY HEREWITH

# EXHIBIT 50

# EXHIBIT 50

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# EXHIBIT 51

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# EXHIBIT 52

# EXHIBIT 52

# POLICY & PROCEDURE
# BILLING CENTER OPERATIONS

**Policy No: 7.1.12**

**Sponsor: April Roga**



**Approved: Tony Vetrano**

**Date of Issue: October 12, 2006**
**Date of Revision: December 28, 2007**
**Date of Revision: December 16, 2008**
**Date of Revision: October 4, 2011**
**Date of Revision: December 6, 2018**
**Date of Revision: October 17, 2019**

**Last Review: October 17, 2019**

**Applicable To: ■ EM ■ HM ■ AN ■ CL ■ UC ■ LABC**

**SUBJECT: APPLYING INDIVIDUAL CONSIDERATION OPTIONS**

## POLICY

Health Care Financial Services of TeamHealth (HCFS) policy is to follow a standard process for providing Individual Consideration (IC) based on the status and specifics of a Managed Care contract and/or payor relationship. Loading IC ensures that the payment is posted according to the explanation of benefits (EOB) and results in the patient being billed only for their deductible, copay and/or coinsurance.

## PROCEDURE

The following are acceptable scenarios for IC loaded in the GE Centricity Business (GECB) pricing module (Fee Schedule 2), PCM, and Contract Maintenance. By loading IC, a payment poster follows the payments, contractual adjustments and patient-responsible amounts as indicated on the payer's EOB. See Attachment A for payor EOB posting examples.

1. **Non Top CPTs –** For every Managed Care contract, the top CPT codes are loaded in GECB with the specific contracted rate. All other CPTs should be loaded using IC. Many of the non top codes are procedures, which often use modifiers that may cause varying allowed amounts. GECB currently does not hold fee variations due to modifiers.

2. **New Negotiations/Not yet contracted –** Managed Care may request a FSC be loaded in GECB as a temporary "IC" while they are negotiating with the carrier on a contract, however, no contract exists for the carrier and the billing area.

   **NOTE:** *During this time, adjustments are not taken because the group/physician is still non-par. If TeamHealth is non-contracted, the EOB will be processed as non-par; therefore, the invoice will be posted according to the non-par rate. In some cases, this means higher co-pays and deductibles for patients. According to TeamHealth policy, we do not adjust co-pays and*

*deductibles for non-contracted plans because this would be considered "ins only," and this is not permitted by matter of law. Furthermore, TeamHealth does not know the patients benefit, and TeamHealth cannot take an adjustment and bill the patient the co-pay as if TeamHealth is contracted because TeamHealth has no idea of what this amount would be.*

3. **Pending Fee Verification** – Typically, during negotiations, TeamHealth must await fee verification (and written documentation) from the plan before fee allowables can be loaded into GECB. In this case temporary "IC" would be loaded to allow payment posters to take the adjustment based on the contracted rate on the EOB.

4. **Multiple Effective Dates for Physicians** – Managed Care may request a FSC be loaded in GECB as "Permanent IC" where a contract exists and is executed, but the rates vary by physician and effective date.

5. **Other Contracted** – Managed Care may request a FSC be loaded in GECB as "Permanent IC" when it is determined that the carrier cannot administer consistently to the reimbursement rates in our contract.

6. **Non-Contracted Care/Caid Replacements** – In the absence of a contract for Medicare or Medicaid Replacement products, billing centers may request a FSC be loaded in GECB as "Non-Contracted IC Medicare Replacement" or "Non-Contracted IC Medicaid Replacement" (Reference HCFS Policy and Procedure 4.6.12, Non-Contracted Medicare & Medicaid Replacement FSCs).

7. **IC Bal Billing Prohibition** – GECB will be loaded as "IC Bal Billing Prohibition" when a payer for a given billing area is covered under state regulations prohibiting balance billing of an HMO member (Reference HCFS Policy and Procedure 4.6.12, Non-Contracted Medicare & Medicaid Replacement FSCs).

8. **Out-of-Network Balance Billing Prevention:** IC will be loaded for any out-of-network FSCs to prevent the patient being billed for any amount outside of deductible, copay and/or coinsurance. Since "Commercial Assigned" FSCs are out-of-network, the following "Commercial Assigned" series of FSCs are loaded as IC: CAS – Commercial Assigned, CS – Second Commercial Insurance, CT – Third Commercial Insurance.

Timeframes are assigned to process various claims based on priority set by Contract Management and IDX Applications, and the timeframes are calculated from the point of receiving a clean loading form, based on the priority as follows:

- Critical 3–5 business days
- High 5–8 business days
- Medium 8–10 business days

# Attachment A
# Payor EOB Examples

Example 1:

| Charges | Excluded Amount | Expenses Paid @100% |
|---|---|---|
| $382.00 | $119.00 | $263.00 |

Action: Adjustment of $119 taken; payment of $263 posted, pt bal is $0

Example 2:

| Billed | Allowed | Contract Adj | Ded | Co-Pay | Paid |
|---|---|---|---|---|---|
| $753.00 | $214.95 | $0 | $0 | $0 | $214.95 |

Action: Adjustment of $538.05 (Billed $753 - Allowed 214.95 = $538.05 **or** Billed $753 - Paid 214.95 - Ded $0 - Co-pay $0 = $538.05); payment of $214.95 posted, pt bal is $0

Example 3:

| Billed | Excluded | Discount | Co-pay | Ded | Allowed | Paid @80% |
|---|---|---|---|---|---|---|
| $647.00 | $59.60 | $0 | $0 | $0 | $587.40 | $469.92 |

Action: Adjustment of $59.60, payment of $469.92 posted, pt bal is $117.48 (Pt bal is billed $647 - Excluded $59.60 - Paid $469.92 = $117.48)

Example 4:

| Billed | Excluded | Discount | Co-pay | Ded | Allowed | Paid @100% | You owe |
|---|---|---|---|---|---|---|---|
| $909.00 | $395.39 | $0 | $0 | $0 | $513.61 | $513.61 | $395.39 |

Action: Adjustment of $395.39, payment of $513.61 posted, pt bal is $0. **Policy allows $395.39 to be adjusted although "you owe" column indicates $395.39. The "you owe" column is based on the excluded amount and not based on a Ded, Co-Pay, or Co-Ins.**

Example 5:

| Submitted | Not covered | Allowed | Ded | Co-pay | Paid @100% | Patient Owes |
|---|---|---|---|---|---|---|
| $630.00 | $210.00 | $420.00 | $0 | $0 | $420.00` | $210 |

Action: Adjustment of $395.39, payment of $420 posted, pt bal is $0. **Policy allows $210 to be adjusted as it is based on the non-covered and not the Ded, Co-Pay, or Co-Ins**

Example 6:

| Billed | Allowed | Co-Pay | Ded | Co-Ins | Paid |
|---|---|---|---|---|---|
| $707.00 | $707.00 | $0 | $147.00 | $112.00 | $448.00 |

Action: No adjustment is taken, payment of $448 is posted, pt bal is $259.00 (Co-Pay + Ded + Co-Ins)

# EXHIBIT 53

# EXHIBIT 53

# FILED UNDER SEAL PURSUANT TO PENDING MOTION TO SEAL FILED CONCURRENTLY HEREWITH

# EXHIBIT 54

# EXHIBIT 54

# FILED UNDER SEAL PURSUANT TO PENDING MOTION TO SEAL FILED CONCURRENTLY HEREWITH

# EXHIBIT 55

# EXHIBIT 55

# FILED UNDER SEAL PURSUANT TO PENDING MOTION TO SEAL FILED CONCURRENTLY HEREWITH