Case Nos. 85525 & 85656

In the Supreme Court of Nevada

UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTH CARE SERVICES, INC.; UMR, INC.; 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.,

Respondents.

Case No. 85525

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Clerk of Supreme Court

UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTH CARE SERVICES, INC.; UMR, INC.; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.; and HEALTH PLAN OF NEVADA, INC.,

Petitioners,

vs.

THE EIGHTH JUDICIAL DISTRICT COURT of the State of Nevada, in and for the County of Clark; and the Honorable NANCY L. ALLF, District Judge,

Respondents,

vs.

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C.; and CRUM STEFANKO AND JONES, LTD.,

Real Parties in Interest.

Case No. 85656

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441	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 3 of 18 (Filed Under Seal)	12/24/21	115 116	28,485–28,643 28,644–28,742
442	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 4 of 18 (Filed Under Seal)	12/24/21	116 117	28,743–28,893 28,894–28,938
443	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 5 of 18 (Filed Under Seal)	12/24/21	117	28,939–29,084
444	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 6 of 18 (Filed Under Seal)	12/24/21	117 118	29,085–29,143 29,144–29,219
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447	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 9 of 18 (Filed Under Seal)	12/24/21	119 120	29,528–29,643 29,644–29,727
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450	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 12 of 18 (Filed Under Seal)	12/24/21	121 122	30,052–30,143 30,144–30,297
451	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 13 of 18 (Filed Under Seal)	12/24/21	122 123	30,298–30,393 30,394–30,516
452	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 14 of 18 (Filed Under Seal)	12/24/21	123 124	30,517–30,643 30,644–30,677
453	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 15 of 18 (Filed Under Seal)	12/24/21	124	30,678–30,835
454	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 16 of 18 (Filed Under Seal)	12/24/21	124 125	30,836–30,893 30,894–30,952
455	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 17 of 18 (Filed Under Seal)	12/24/21	125	30,953–31,122
456	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 18 of 18 (Filed Under	12/24/21	125 126	30,123–31,143 31,144–31,258

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160	Transcript of Proceedings Re: Motions	10/22/21	24 25	5908–6000 6001–6115
459	Transcript of Proceedings Re: Motions (Filed Under Seal)	01/12/22	127	31,501–31,596
460	Transcript of Proceedings Re: Motions (Filed Under Seal)	01/20/22	127 128	31,597–31,643 31,644–31,650
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319	Transcript of Proceedings Re: Motions Hearing	04/07/22	68	16,837–16,855
323	Transcript of Proceedings Re: Motions Hearing	04/21/22	69	17,102–17,113
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39	Transcript of Proceedings, All Pending Motions	06/09/20	6	1385–1471
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482	Transcript of Status Check (Filed Under Seal)	10/10/22	142	35,248–35,258
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CERTIFICATE OF SERVICE

I certify that on April 18, 2023, I submitted the foregoing appendix for filing *via* the Court's eFlex electronic filing system.

Electronic notification will be sent to the following:

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I further certify that I served a copy of this document by mailing a true and correct copy thereof, postage prepaid, at Las Vegas, Nevada, addressed as follows:

The Honorable Nancy L. Allf
DISTRICT COURT JUDGE – DEPT. 27
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/s/ Jessie M. Helm
An Employee of Lewis Roca Rothgerber Christie LLP

6. On January 23, 2020, I sent a letter detailing the deficiencies in Plaintiffs' responses to Defendants' written discovery requests discussed in paragraph 3 *supra*, including a request that Plaintiffs "provide an estimate of the amount of time it would take to compile the documents at issue in this Request and the accompanying costs." **Exhibit 3.** I also requested that the parties attend a telephonic conference to discuss the issues. *Id*.

7. On February 13, 2020, I and my colleague, Brittany M. Llewellyn, attended a telephonic meet and confer with Plaintiffs' counsel, Kristen Gallagher and Amanda Perach, regarding the issues stated in Defendants' January 23, 2020 correspondence. During that conference, Plaintiffs confirmed that they would not supplement their responses to Request No. 6 or produce discovery of any Clinical Records.

8. Later that same day, Ms. Llewellyn sent correspondence to Ms. Gallagher and Ms. Perach summarizing our conference call and the parties' respective positions. **Exhibit 4.** In the February 13, 2020 email correspondence, Ms. Llewellyn advised Ms. Gallagher and Ms. Perach that, without any agreement to supplement, Defendants would be filing a motion to compel as to Plaintiffs' deficient response to Request No. 6. **Exhibit 4.**

9. To date, Plaintiffs have not produced discovery of ***any*** Clinical Records for ***any*** of their claims in the Claims Spreadsheet, despite receiving Defendants' Request No. 6 on June 28, 2019. This amounts to a delay of over 14 months.

10. Defendants hoped to avoid this Motion by reaching a reasonable compromise, but it is now apparent that Plaintiffs do not intend to produce discovery of Clinical Records for ***any*** of their claims in the Claims Spreadsheet, which will severely prejudice Defendants' ability to defend against Plaintiffs' claims

11. In addition, Plaintiffs' initial disclosures were produced on October 2, 2019. However, to date, Plaintiffs have not produced any Explanation of Benefits ("EOB") or Provider Remittance Advice ("PRA") documents. Despite this, Plaintiffs have produced the Claims Spreadsheet that contains damages calculations based on data allegedly pulled from EOBs and PRAs. Thus, such documents should have been produced with Plaintiffs' initial disclosures.

12. The discovery cutoff in this matter is December 31, 2020.

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13. Based on the foregoing, Defendants request that this Court set this Motion to Compel on an order shortening time to resolve this narrow and important dispute. Specifically, and in accordance with the Court's statements at the September 9, 2020 hearing on Plaintiffs' Motion to Compel, Defendants request that the hearing be set at the same time as the previously scheduled September 30, 2020 status conference. This request is in accordance with the Court's directive at the September 9, 2020 hearing, where the Court stated, "then if you guys have Motion to Compel on either side, because I heard it from both sides, I would consider those also on the 30th." **Exhibit 5** (Transcript at 64:10-12).

14. Defendants also respectfully submit that good cause exists to grant the order shortening time because the narrow and important discovery issues that are involved in Defendants' Motion should be quickly heard and adjudicated, given (1) the upcoming discovery deadline and (2) Plaintiffs' flat refusal to produce the requested discovery, which is critical to Defendants' defenses.

15. I declare that the foregoing is true and correct under the penalty of perjury under the laws of the state of Nevada.

DATED: September 18, 2020

/s/ Colby L. Balkenbush
Colby L. Balkenbush, Esq.

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ORDER SHORTENING TIME

Good cause appearing therefor, IT IS HEREBY ORDERED that the hearing on **DEFENDANTS' MOTION TO COMPEL PRODUCTION OF CLINICAL DOCUMENTS FOR AT-ISSUE CLAIMS AND DEFENSES AND TO COMPEL PLAINTIFFS' TO SUPPLEMENT THEIR NRCP 16.1 INITIAL DISCLOSURES** shall be shortened and heard before the above-entitled Court in Department XXVII on the 30th day of September 2020 at 1:30 a.m./p.m., or as soon thereafter as counsel may be heard; that Plaintiffs' opposition, if any, shall be electronically filed and served on or before the _____ day of _____, 2020.

Dated this 21st day of September, 2020

Nancy L Allf

DISTRICT COURT JUDGE

F28 481 989B 127A
Nancy Allf
District Court Judge

Submitted By:

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MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

This Court is familiar with the basics of the dispute before it. The TeamHealth Nevada Plaintiffs ("Plaintiffs") are private-equity backed out-of-network healthcare providers who have asserted an unjust enrichment claim alleging that Defendants have underpaid plan benefits for emergency medical services provided to participants of health plans administered by Defendants. Conversely, Defendants contend that Plaintiffs' charges were grossly inflated, improperly "up-coded," and that Plaintiffs are not entitled to anything more than what has already been paid. Thus, a core question that needs to be resolved under Plaintiffs' legal theory is: What was the reasonable value of the services that Plaintiffs provided and did Defendants adequately reimburse Plaintiffs for that value? *See, e.g.*, First Amended Complaint at ¶ 62 ("Defendants are obligated to reimburse the Health Care Providers . . . for the reasonable value of the services provided.").[3] The instant Motion seeks discovery of the Clinical Records, as defined in Section II, *infra*, to assist in resolving that core question and to allow for a determination as to whether Plaintiffs are entitled to any additional reimbursement for the medical services that they allege underlie each of the at-issue claims.

Plaintiffs' refusal to produce the requested discovery goes hand-in-hand with Plaintiffs' attempts to discharge their burden to prove that they actually performed the services for which they seek over $26 million dollars in additional reimbursements. They seek to only rely on unverified summary claims data in a spreadsheet stamped FESM000344 (the "Claims Spreadsheet"),[4] which is simply not enough.

In addition, Defendants, for their part, have specifically asserted setoff and other affirmative defenses specifically challenging Plaintiffs' right to the millions of dollars in

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[3] As detailed more fully in Defendants' May 26, 2020 Motion to Dismiss, and in their pending writ petition, Defendants contend that they were only required to pay Plaintiffs in accordance with Plaintiffs' patients' controlling health plans, but will not reiterate those arguments here in this narrow Motion.

[4] The Claims Spreadsheet is being produced via email to the Court for *in-camera* review because it contains confidential protected health information that may not be filed in open court pursuant to the Stipulated Protective Order entered on June 24, 2020.

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additional reimbursements they claim are due and owing. To prove those defenses, Defendants are entitled to challenge Plaintiffs' performance of the alleged medical services they reported in each of their claims forms, as well as the validity of their claims data. Thus, for Plaintiffs to carry their burden and for Defendants to support their defenses, it is critical that discovery of the Clinical Records be ordered. There is no dispute that claims-specific discovery is appropriate in this case. Indeed, Plaintiffs have already demanded claim-specific discovery from the Defendants and moved to compel Defendants to produce 22,153 administrative records, a motion this Court granted. Defendants now seek a reciprocal and equivalent order from the Court—without it, Defendants will be severely and unfairly prejudiced.

Accordingly, Defendants move to compel Plaintiffs to produce documents responsive to Defendants' Request for Production No. 6 ("Request No. 6"), which was served upon Plaintiffs on June 28, 2019, seeking discovery of the Clinical Records for each of the claims in the Claims Spreadsheet, as well as an order directing Plaintiffs to comply with NRCP 16.1.

II. REQUEST NO. 6 AND PROCEDURAL BACKGROUND

Request No. 6 seeks:

> 6. Please produce all documents concerning the medical treatment that Fremont allegedly provided to the more than 10,800 patients referenced in paragraph 25 of the Complaint.[5]

Request No. 6 was served prior to the filing of Plaintiffs' First Amended Complaint, and prior to Plaintiffs placing nearly 7,000 more claims at issue in this case. Request No. 6 should therefore be construed to conform to the pleadings. (Balkenbush Decl. at ¶ 3.) Request No. 6 therefore seeks discovery of the Clinical Records[6] for the medical services related to all 22,153 claims in the Claims Spreadsheet. *Id.*

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[5] *See* Defendants' First Set of Requests for Production, **Exhibit 1**.

[6] As used in this Motion, the term "Clinical Records" is intended to be consistent with the definition of "health care records" in NRS 629.021 to mean Plaintiffs' provider or facility records, including, but not limited to, medical charts, patient medical history, patient files, medical records, providers' notes, treatment plans, assessments, diagnoses, pharmacy and medication records, testing and laboratory records and results, radiology images and reports, and providers' orders, and records of all procedures, treatments, and services rendered related to a specific claim. This definition also encompasses electronic medical and health records.

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As of this date, Plaintiffs have failed to produce discovery for a single Clinical Record for ***any*** of the claims in the Claim Spreadsheet. Balkenbush Decl. at ¶¶ 10-11. Instead, Plaintiffs have offered boilerplate burden objections, including, in relevant part, that:

> The request is overly broad, irrelevant and not proportional to the needs of the case considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit as this case concerns a dispute over the rate of payment rather than a coverage determination and, consequently, does not concern the medical treatment provided to particular patients. In particular, the medical records of the 10,800 patients referenced in paragraph 25 of the Complaint are records unrelated to the dispute at issue, making such information unimportant to the issues at stake in this action.
>
> Finally, the burden and expense of gathering thousands of medical records, adequately redacting confidential and information protected by HIPAA and producing this exceedingly large file outweighs any benefit.[7]

In lieu of producing the relevant Clinical Records underlying the at-issue claims, Plaintiffs first offered a spreadsheet of an initial 15,210 claims.[8] Then, when they later supplemented their responses, they produced the Claims Spreadsheet containing 22,153 claims.[9] (Balkenbush Decl. at ¶ 5.) The information in the Claims Spreadsheet was solely compiled by Plaintiffs and is otherwise unverified.

Separately, as discussed in Section III(D), Defendants seek an order requiring Plaintiffs to comply with NRCP 16.1 and to supplement their initial disclosures from October 2019 by producing certain documents that demonstrate (1) what was billed and paid for each claim in the Claims Spreadsheet, and (2) the values utilized by Plaintiffs for their computation of damages.

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[7] *See* Plaintiffs' initial responses to Defendants' First Set of Requests for Production, **Exhibit 1**.

[8] *Id.* and FESM000011.

[9] *See* Plaintiffs' supplemental responses to Defendants' First Set of Requests for Production, **Exhibit 6** and FESM000344.

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III. LEGAL ARGUMENT

A. Legal Standard for Motion to Compel

NRCP 26(b)(1) allows parties to discover any non-privileged matter "which is relevant to the subject matter involved in the action," including any documents relating to either party's claims and defenses. NRCP 26(b)(1). Because of the broad discovery rules, the party resisting discovery must carry the heavy burden of showing why discovery should be denied. *See Daisy Tr. v. JP Morgan Chase Bank., N.A.*, 2017 WL 3037427, at *2 (D. Nev. July 18, 2017). To meet this burden, "the resisting party must specifically detail the reasons why each request is improper." *Magdaluyo v. MGM Grand Hotel, LLC*, 2016 WL 2731672, at *3 (D. Nev. May 9, 2016).

Defendants' request for discovery of Clinical Records responsive to Request No. 6 is appropriate and proper here because: (1) Plaintiffs have failed to provide support for their undue burden objections; (2) Plaintiffs necessarily must rely on the Clinical Records to carry their burden in proving an entitlement to additional reimbursements on an unjust enrichment theory; and (3) Defendants' defenses require the essential discovery sought by this Motion.

B. Plaintiffs Have Failed to Provide Support For Their Undue Burden Objections By Way of An Affidavit or Declaration

Plaintiffs have objected to producing discovery of Clinical Records on the basis that, *inter alia*, "the burden and expense of gathering thousands of medical records, adequately redacting confidential and information protected by HIPAA and producing this exceedingly large file outweighs any benefit."[10] Defendants, in response, have requested that Plaintiffs provide an estimate of the amount of time it would take to compile the documents and the accompanying costs.[11] Plaintiffs, however, have refused to do so.[12]

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[10] *See* Plaintiffs' initial responses to Defendants' First Set of Requests for Production, **Exhibit 1**.

[11] Declaration of Colby L. Balkenbush ¶ 6; **Exhibit 3**.

[12] Plaintiffs are for-profit, private equity-backed out-of-network medical providers affiliated with one of the largest national physician management companies in the United States, TeamHealth Holdings, Inc. ("TeamHealth"). They have not offered any affirmation in support of their contention that the production of these records would amount to an undue burden or expense, which is difficult to understand given their TeamHealth affiliation.

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As the party resisting discovery, Plaintiffs must demonstrate that the information sought by Defendants is not reasonably accessible because of undue burden or cost. *See* NRCP 26(b)(2)(B). "**[A]n objection that a discovery request is 'unduly burdensome' must be supported by a declaration to carry weight**." *Bresk v. Unimerica Ins. Co.*, 2017 WL 10439831, at *3 (C.D. Cal. Nov. 16, 2017); *see also Jackson v. Montgomery Ward & Co.*, 173 F.R.D. 524, 528–29 (D. Nev. 1997) ("party claiming that a discovery request is unduly burdensome must allege specific facts which indicate the nature and extent of the burden, usually by affidavit or other reliable evidence."). "[T]he fact that discovery may involve some inconvenience or expenses is not sufficient, standing alone, to avoid the discovery process." *Martinez v. James River Ins. Co.*, 2020 WL 1975371, at *1 (D. Nev. Apr. 24, 2020). Plaintiffs should not be allowed to avoid their obligation to demonstrate burden with respect to Request No. 6.[13]

As of this date, Plaintiffs have not withdrawn their burden objections to Request No. 6. Because Plaintiffs' objections lack any evidentiary support, they should be stricken or overruled, and Plaintiffs should be ordered to produce discovery of the Clinical Records for the claims identified in the Claims Spreadsheet, which Plaintiffs put at issue when they filed their Complaint.

C. Plaintiffs Should be Compelled to Produce Discovery of Clinical Records Because They are Critical to the Claims and Defenses in the Case

In addition to their stated burden objections, Plaintiffs have also objected to producing documents responsive to Request No. 6 as "unrelated to the dispute" **Exhibit X**. Plaintiffs' objection is incorrect for a several reasons discussed below.

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[13] Of note, on September 9, 2020, the Court ordered Defendants to produce the administrative records for the 22,153 at-issue claims *despite* Defendants' detailed 5 page burden declaration. Here, no burden declaration has been produced making the case even stronger for ordering production.

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1. Defendants have the right to contest the value and performance of the underlying medical services at issue in each of Plaintiffs' claims in the Claims Spreadsheet.

Plaintiffs must prove that the services for which they seek additional reimbursement were actually performed as billed. *See Sacred Heart Health Sys., Inc. v Humana Military Healthcare Serv.'s, Inc.*, No. 3:07-cv-00062-MCR-EMT at *32 (N.D. Fla. Oct. 21, 2011) (plaintiffs who have placed in issue the underpayments "will be required to demonstrate that they performed services identified in the individual claim forms[,] . . . not just that the [p]laintiffs reported the services"). Plaintiffs cannot carry this burden with the "generalized proof" provided in the form of summary claims data alone. *See Sacred Heart*, No. 3:07-cv-00062-MCR-EMT at *17 (N.D. Fla. Mar. 30, 2012) (requiring production of clinical records supporting underpayment claims on the grounds that the claims forms do not "certify that the claim form was accurately coded, that it accurately described the services or the medical need for them, or that the services were *actually performed*") (emphasis added). **Exhibit 7** (Oct. 21, 2011 Order and Mar. 30, 2012 Order).

Even if Plaintiffs' claims data in the Claims Spreadsheet could serve as sufficient evidence for proving performance of the underlying medical services, Defendants have a right to contest that evidence and explore Plaintiffs' contentions through other evidence, including through Plaintiffs' Clinical Records. *See Sacred Heart*, No. 3:07-cv-00062-MCR-EMT at *16-17 (N.D. Fla. Oct. 21, 2011) ("As a matter of due process Defendant [health plan] should be entitled to investigate . . . services not provided or [] monies paid for services for which Plaintiffs were not entitled."). Plaintiffs' objections and refusal to produce discovery of the Clinical Records thus deprives Defendants of that "due process" right. *See id at 21; see also In re Managed Care Litigation*, MDL No. 1334, Master File No. 00-1334-MD-MORENO (S.D. Fla. July 24, 2003 (recognizing that health insurers have a right to discovery on claim-specific documents, such as medical records, in the context of physicians' allegation that the health plan improperly reimbursed their claims).[14]

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[14] The U.S. District Court for the Southern District of Florida's decision in the *In re Managed Care* litigation also provides a good example of a decision recognizing a health insurer's right to contest performance. *In re Managed Care* involved, among other things, a breach of contract action by thousands of doctors against the nation's largest health insurers over claims for services allegedly

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Plaintiffs effectively ask this Court to ***assume*** the validity of their claims and the accuracy of their claims data in the Claims Spreadsheet. But by seeking additional reimbursement of plan benefits for the claims for which they have already been paid, Plaintiffs have placed "the accuracy of those claims . . . directly in issue." *Sacred Heart*, No. 3:07-cv-00062-MCR-EMT at *31 (N.D. Fla. Oct. 21, 2011). Defendants are entitled to discovery that may allow them to "challenge the validity of the individual claims," including in the Claims Records. *Sacred Heart*, No. 3:07-cv-00062-MCR-EMT at *31 (N.D. Fla. Mar. 30, 2012) (rejecting plaintiff hospitals' argument that "[the defendant-insurer] should not be permitted to challenge the underlying validity of the claims at issue," and holding that "[the defendant-insurer] has a legal right to go beyond the claim forms" and take discovery on the underlying claims).

Moreover, absent claim-specific proof, it is impossible to know whether there are any errors—be they relatively minor or systemic—in Plaintiffs' claims data in the Claims Spreadsheet. Plaintiffs cannot guarantee the accuracy of the unverified claims data and the performance of the underlying services by their own say-so; rather, they must produce discovery of the Clinical Records relating to the disputed claims that allow Defendants to examine the integrity of their claims data and pursue proof to support their defenses.

In a case where Plaintiffs are seeking over $26 million dollars in additional reimbursements, there is no good-faith basis for avoiding discovery of their Clinical Records.

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rendered by the doctors to members of the defendant health plans. In that case, the health insurers sought discovery of clinical records in order to investigate the accuracy of the claim forms the doctors put at issue. The physicians in that case, like Plaintiffs here, refused to produce those clinical records; however, the district court made short work of that argument and compelled production of the requested clinical records. (Order Adopting in Part Rep. & Recs., *In re Managed Care Litig.*, MDL No. 1334, Master File No. 00-1334-MD-MORENO (S.D. Fla. July 24, 2003); Rep. & Rec., *In re Managed Care Litig.*, MDL No. 1334, Master File No. 00-1334-MDL-MORENO (July 3, 2003) (both orders attached as **Exhibit 8**).

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2. Plaintiffs' cause of action for unjust enrichment requires discovery of Plaintiffs' Clinical Records.

Plaintiffs contend that "this case concerns a dispute over the rate of payment rather than a coverage determination and, consequently, does not concern the medical treatment provided to particular patients."[15] But Plaintiffs call into question the reasonable value "of the services provided" in their First Amended Complaint:

> Defendants accepted and retained the benefit of the services provided by the Health Care Providers at the request of the members of its Health Plans, knowing that the Health Care Providers expected to be paid a usual and customary fee based on locality, or alternatively for ***the reasonable value of services provided***, for the medically necessary, covered emergency medicine services it performed for Defendants' Patients.

(FAC at ¶ 225 (emphasis added).) Plaintiffs further allege that they are "entitled to recover the difference between the amount the Defendants' paid for emergency care the Health Care Providers rendered to its members and the ***reasonable value*** of the service that the Health Care Providers rendered . . . ." (FAC at ¶ 225 (emphasis added)).

To litigate Plaintiffs' unjust enrichment claim, discovery as to the value of the benefit allegedly conferred, which includes the reasonable value of Plaintiffs' services as a whole, is necessary. *Id.* "When a plaintiff seeks 'as much as he . . . deserve[s]' based on a theory of restitution . . . he must establish each element of unjust enrichment,"[16] *Certified Fire Prot. Inc. v. Precision Constr.*, which requires a showing that the plaintiff conferred a benefit on the defendant, the defendant appreciated such benefit, and that there is acceptance and retention of the benefit under circumstances. *Certified Fire*, 128 Nev. at 381, 283 P.3d at 257 (quoting BLACK'S LAW DICTIONARY 1361 (9th ed. 2009)).[17] Plaintiffs are not discharged from their obligation to demonstrate that a benefit was conferred "from [the] services provided." *Id.*

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[15] *See* Plaintiffs' initial responses to Defendants' First Set of Requests for Production, **Exhibit 1**, at 5:14–16.

[16] 1 Dan B. Dobbs, Dobbs Law of Remedies § 4.2(3) (2d ed. 1993) (plaintiff pursuing quantum meruit under unjust enrichment theory must show benefit to defendant).

[17] *See also* Restatement (Third) of Restitution and Unjust Enrichment § 49 (2011) ("Enrichment from the receipt of nonreturnable benefits may be measured by (a) the value of the benefit in advancing the

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It is also generally accepted that "a medical care provider's billed price for particular services is not necessarily representative of either the cost of providing those services or their market value." *Howell v. Hamilton Meats & Provisions, Inc.*, 52 Cal. 4th 541, 564, 257 P.3d 1130, 1144 (2011). And, "[i]n a given case, the reasonable and customary amount that the health care service plan has a duty to pay 'might be the bill the [medical provider] submits, or the amount the [health care service plan] chooses to pay, or some amount in between.'" *Children's Hosp. Cent. California v. Blue Cross of California*, 226 Cal. App. 4th 1260, 1275, 172 Cal. Rptr. 3d 861, 873 (2014) (citing *Prospect Med. Grp., Inc. v. Northridge Emergency Med. Grp.*, 45 Cal. 4th 497, 505, 198 P.3d 86, 91 (2009)). Here, because the measure of liability and damages for Plaintiffs' unjust enrichment claim, as alleged, requires "a determination of the value of the goods or services at issue," and because Plaintiffs seek damages for "the reasonable value of the services provided,"[18] Defendants are entitled to independently examine and contest the "value" of the services at issue, which necessarily includes analyzing discovery of the Clinical Records. *See Certified Fire*, at 128 Nev. at 380, 283 P.3d at 256.[19]

In sum, discovery in the form of Clinical Records is warranted in light of Plaintiffs' unjust enrichment claim; a determination as to "reasonable value for the services," which is what Plaintiffs contend they seek, simply cannot be derived from the unverified Claims Spreadsheet generated by Plaintiffs.

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purposes of the defendant, (b) the cost to the claimant of conferring the benefit, (c) the market value of the benefit, or (d) a price the defendant has expressed a willingness to pay, if the defendant's assent may be treated as valid on the question of price.").

[18] *See* Plaintiffs' First Amended Complaint at ¶¶ 62, 69, 211, 220, 225; *See also* Plaintiffs' Answer to Interrogatory No. 5, at **Exhibit 9** ("Fremont is not obligated to provide emergency services to UnitedHealthcare members at rates that are not usual and customary or reflective of the reasonable value of the emergency medical services provided.").

[19] Any contention by Plaintiffs that they can unilaterally set prices for the services rendered that bears no relationship to the reasonable value for those services is untenable.

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3. Discovery of Clinical Records is necessary for Defendants' affirmative defenses and without it, Defendants will be unfairly prejudiced.

Defendants have asserted affirmative defenses in their answer to Plaintiffs' First Amended Complaint, two of which require discovery of the Clinical Records sought by this Motion.

For Defendants' Twenty-Fourth Affirmative Defense:

> Plaintiffs' claims are subject to setoff and/or recoupment with respect to claims for which United made payment on the basis of current procedural terminology ("CPT") or other billing codes included in Plaintiffs' submissions that Plaintiffs' **clinical records** of their patients' care reveal to have been improperly submitted, either because Plaintiffs' **clinical records** do not support submission of the codes at all, or because Plaintiffs' **clinical records** establish that different codes should have been submitted.

Exhibit 10 at pp. 47-48 (emphasis added). For Defendants' Twenty-Fifth Affirmative Defense:

> Plaintiffs' claims are subject to setoff and/or recoupment with respect to claims for which United made payment on the basis of Plaintiffs' billed charges and those billed charges exceeded the billed charges submitted to other payors, where Plaintiffs never intended to collect such charges from any other payors, or where the charges were otherwise in error.[20]

Id.

As Defendants have the burden of proof for their affirmative defenses, they are entitled to discover evidence relevant and necessary to substantiate those defenses. *See* NRCP 26(b)(1). As to Defendants' Twenty-Fourth Affirmative Defense, Defendants seek discovery of Clinical Records to determine whether such documentation supports the submission of the CPT codes that were utilized (*see* the Claims Spreadsheet), or whether different codes should have been submitted for the services rendered to Defendants' members. **Exhibit 10** at pp. 47-48. Similarly, as to Defendants' Twenty-Fifth Affirmative Defense, Defendant contend that any liability or damages is subject to setoff and/or recoupment, including in instances where overpayments of plan benefits were made as the result of Plaintiffs' improper CPT coding

[20] *See* Defendants' Answer to Plaintiffs' First Amended Complaint.

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practices. *Id*. Defendants are entitled to analyze the Clinical Records underlying Plaintiffs' billed charges to support this defense.

Additionally, discovery of Clinical Records will be essential to the analysis of Defendants' experts for market analyses, coding trend analyses, and their examination of Plaintiffs' inflated billed charges. Defendants should be permitted to marshal proof at trial that Plaintiffs' billed charges were grossly inflated,[21] that Plaintiffs billed for certain services that were never performed or did not meet "emergent" thresholds, and that CPT codes were inappropriately used relative to the services provided. *See Adventist Health Sys., Inc. v. Blue Cross and Blue Shield of Fla., Inc.*, 2008-CA-011145 (Fla. 9th Cir. Ct. Orange Cty., Jun. 10, 2010) (in a reimbursement dispute the court ordered the provider to produce all responsive documents concerning, among other things, "evaluation of whether a patient who presents to the emergency room has an emergency condition") (attached as **Exhibit 11).** Without discovery of the Clinical Records, Defendants will be prejudiced and unable to make this showing at trial, including fundamentally challenging whether a particular claim was underpaid or overpaid, for purposes of liability and damages.

Plaintiffs' refusal to produce the Clinical Records prevents Defendants from taking discovery and offering proof that contests (1) whether Plaintiffs actually performed the services described on the claims as billed, (2) whether those services are indeed the services that are identified in their claims data, (3) whether Defendants are actually the party responsible for paying those claims or portions of claims, and (4) whether the at-issue claims were billed and coded appropriately under the applicable CPT coding guidelines. Plaintiffs should therefore be ordered to produce the Clinical Records.

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[21] Nationwide billing rates and practices for TeamHeath-affiliated providers have been the subject of investigations and lawsuits. A recent class action by patients alleges that TeamHealth charges nearly three times the median rate for in-network physicians at participating hospitals, and their billed charges are significantly higher, at more than four times the median rate. The lawsuit, brought by patients of TeamHealth, asserts federal racketeering claims that bring TeamHealth's rates under serious scrutiny. *See Fraser v. Team Health Holdings, Inc.*, Case 3:20-cv-04600-LB, Doc. 1 (N.D. Ca. Filed July 10, 2020).

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D. Plaintiffs should be compelled to Comply with NRCP 16.1

In addition to discovery of the Clinical Records, Defendants also seek an order requiring Plaintiffs to comply with NRCP 16.1(a)(1)(A)(ii), which provides that a party must produce, without awaiting a discovery request:

> a copy — or a description by category and location — of all documents, electronically stored information, and tangible things that the disclosing party has in its possession, custody, or control and may use to support its claims or defenses, including for impeachment or rebuttal, and, unless privileged or protected from disclosure, **any record**, report, or witness statement, **in any form, concerning the incident that gives rise to the lawsuit**;

NRCP 16.1(a)(1)(A)(ii) (emphasis added).

Here, the production of "Explanation of Benefits" and "Provider Remittance Advice" documents or, hereinafter "EOBs" and "PRAs," provide a summary of the medical services for the claims at issue. Plaintiffs were therefore required to produce these documents with their Initial Disclosures in October of 2019. Instead, Plaintiffs have produced nothing more than the Claims Spreadsheet, which as noted *supra*, contains only summarized data. But the data in the Claims Spreadsheet is presumably based on the EOBs and PRAs. Therefore, the EOBs and PRAs are at the core of this dispute, and yet Plaintiffs have not produced a single one of these fundamental documents which are admittedly in their possession.[22]

These documents should likewise have been produced pursuant to NRCP 16.1(a)(1)(A)(iv), which requires that a party "must make available for inspection and copying as under Rule 34 ***the documents or other evidentiary material, unless privileged or protected from disclosure, on which [their] computation [of damages]*** is based." NRCP 16.1(a)(1)(A)(iv) (emphasis added). Because Plaintiffs' computation of damages—set forth in their Claims Spreadsheet—is based on the provider EOBs and PRAs, NRCP 16.1 requires production of such documents.

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[22] *See* Transcript of Proceedings from September 9, 2020 Hearing on Plaintiffs' Motion to Compel, **Exhibit 5**, at 27:11–13 ("**we were already in receipt of is the EOBs, the member explanation of benefits, and then the provider remittance advices, or was referred to as PRAs**.") (emphasis added).

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IV. RELIEF REQUESTED

Based on the foregoing, Defendants respectfully request an order that Plaintiffs be compelled to produce discovery of the Clinical Records for the 22,153 claims at issue in this litigation, as detailed in the Claims Spreadsheet. Alternatively, if this Court believes a more limited initial production of clinical records is more appropriate at this juncture, Defendants will be prepared to make a more limited request at the September 30 hearing based on further review of the Claims Spreadsheet, and based on an initial draft of the claim matching spreadsheet Defendants alluded to in their opposition brief dated September 4, 2020, which they expect to receive in the interim. Should the Court be inclined to grant a more limited request, Defendants reserve their right to move again for the complete set of Clinical Records for the total 22,153 claims, based on the billing and/or coding errors, as well as other irregularities, that are discovered in the subset of Clinical Records to be produced by Plaintiffs.

Finally, Defendants request that Plaintiffs be ordered to produce the EOB and PRA documents pursuant to NRCP 16.1, which support the computation of damages in Plaintiffs' Claims Spreadsheet.

Dated this 18th day of September, 2020.

/s/ Colby L. Balkenbush

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CERTIFICATE OF SERVICE

I hereby certify that on the 18th day of September, 2020, a true and correct copy of the foregoing **DEFENDANTS' MOTION TO COMPEL PRODUCTION OF CLINICAL DOCUMENTS FOR THE AT-ISSUE CLAIMS AND DEFENSES AND TO COMPEL PLAINTIFFS TO SUPPLEMENT THEIR NRCP 16.1 INITIAL DISCLOSURES ON AN ORDER SHORTENING TIME** was electronically filed and served on counsel through the Court's electronic service system pursuant to Administrative Order 14-2 and N.E.F.C.R. 9, via the electronic mail addresses noted below, unless service by another method is stated or noted:

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EXHIBIT 1

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UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation, Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC. dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC. dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: 2:19-cv-00832-JAD-VCF **DEFENDANTS' FIRST SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS TO FREMONT**

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Defendants UnitedHealthcare Insurance Company ("UHIC"), United HealthCare Services, Inc. ("UHS"), UMR, Inc. ("UMR"), Oxford Health Plans, Inc. ("Oxford"), Sierra Health and Life Insurance Co., Inc. ("SHL"), Sierra Health-Care Options, Inc. ("SHO"), and Health Plan of Nevada, Inc. ("HPN") (collectively "Defendants"), request that Plaintiff Fremont Emergency Services (Mandavia), Ltd. ("Fremont," "you," or "your") produce the documents and things requested below at the offices of Weinberg, Wheeler, Hudgins, Gunn, & Dial, 6385 South Rainbow Boulevard, Suite 400, Las Vegas, Nevada 89118 within 30 days of the date of service of this request in accordance with Federal Rule of Civil Procedure 34. In responding to these requests, adhere to the following definitions and instructions.

DEFINITIONS

Notwithstanding any definition below, each word, term, or phrase used herein is intended to have the broadest meaning permitted under the Federal Rules of Civil Procedure.

1. "Document" is defined to be synonymous in meaning and equal in scope to the usage of this term in Federal Rule of Civil Procedure 34(a), which includes, but is not limited to, all electronic, written, or printed matter, information, communication, or data of any kind, including the originals and all copies thereof, such as, but not limited to, correspondence, letters, emails, text messages, electronic messages, contracts, reports, memoranda, notes, minutes, receipts, invoices, calendar entries, digital images, digital recordings, photographs, microfiche, videotapes, spreadsheets, drawings, all electronically stored information, unstructured data, and structured data. A draft of a nonidentical copy is a separate document within the meaning of this term.

2. "Communication" refers to the transmittal of information (in the form of facts, ideas, inquiries, or otherwise).

3. "Concerning" means relating to, referring to, describing, evidencing, or constituting.

4. "Fremont," "you," and "your" refer to Plaintiff Fremont Emergency Services (Mandavia), Ltd. and its past or present officers, directors, employees, corporate parents, subsidiaries, successors, predecessors, affiliates, agents, subcontractors and any other persons or

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entities who obtained or maintained information on its or their behalf.

5. "Action" refers to this litigation that is pending in Nevada Federal District Court, Case No.: 2:19-cv-00832-JAD-VCF.

6. "Defendants" refers to UnitedHealthcare Insurance Company ("UHIC"), United HealthCare Services, Inc. ("UHS"), UMR, Inc. ("UMR"), Oxford Health Plans, Inc. ("Oxford"), Sierra Health and Life Insurance Co., Inc. ("SHL"), Sierra Health-Care Options, Inc. ("SHO"), and Health Plan of Nevada, Inc. ("HPN") and their past or present officers, directors, employees, corporate parents, subsidiaries, successors, predecessors, affiliates, and agents.

7. "Healthcare Claims" has the same meaning as the term "healthcare claims" in paragraph 27 of the Complaint.

8. "Health Insurance Claim Form" refers to a standard form in the health industry that typically sets forth, among other things, the patient name, address, the diagnosis or nature of the illness or injury, the date the medical service was provided, the charges incurred for the medical service and the medical provider's name. Two representative examples of Health Insurance Claim Forms are attached hereto as **Exhibit 1**.

INSTRUCTIONS

1. Produce all documents known or available to you after making a diligent search of your records that are within your possession, custody, or control, or in the possession, custody, or control of your counsel, agents, or representatives, or which can be obtained through reasonably diligent efforts.

2. Construe each request in accordance with the following: (i) construe each request for production independently; do not construe any request so as to limit the scope of any other request; (ii) references to the singular include the plural and vice versa; (iii) references to one gender include the other gender; (iv) references to the past include the present and vice versa; (v) disjunctive terms include the conjunctive and vice versa; (vi) the words "and" and "or" are conjunctive and disjunctive as necessary to bring within the scope of the request all responses that might otherwise be construed to be outside of its scope; (vii) the word "all" refers to all and each, and (viii) the word "each" refers to all and each.

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3. If any document or thing requested was at one time in existence, but is no longer in existence, please so state, specifying for each document and thing, (a) the type of document or thing, (b) the types of information contained therein, (c) the date upon which the document or thing was destroyed or ceased to exist, (d) the circumstances under which it was destroyed or ceased to exist, (e) the identity of all persons having knowledge of the circumstances under which it was destroyed or ceased to exist, and (f) the identity of all persons having knowledge or persons who had knowledge of the contents thereof.

4. If you object to a request, state your objection with specificity and state whether any responsive materials are being withheld on the basis of that objection.

5. If, in responding to these requests, you claim any ambiguity in interpreting either a request or a definition or instruction applicable thereto, you cannot use such a claim as a basis for failing to respond; instead, you must set forth as part of your response to the request the language deemed to be ambiguous and the interpretation chosen to be used in responding to the request.

6. If, in responding to these requests, you assert a privilege to any particular request, provide a privilege log as required by Fed. R. Civ. P. 26(b)(5), which identifies the nature of the claimed privilege and, at a minimum, includes enough information so that the propounding party and the Court can make an informed decision whether the matter is indeed privileged.

7. Each request is continuing in nature. If, after responding to these requests, you obtain or become aware of further documents responsive to these requests, promptly produce those documents and things in accordance with Fed. R. Civ. P. 26(e) and the definitions and instructions herein.

REQUESTS FOR PRODUCTION OF DOCUMENTS

1. Please produce a list, chart, spreadsheet and/or table showing all the Healthcare Claims that Fremont is asserting in this Action. This document(s) should include, at a minimum, the following information: (a) the patient's name, (b) the patient's date of birth, (c) the patient's social security number, (d) the patient/insured's I.D. number, (e) the patient's account number, (f) the name of the medical provider, (g) the date the medical service was provided, (h) the

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amount billed by Fremont for the medical service, (i) the amount Defendants paid to Fremont, (j) the additional amount of reimbursement Fremont is demanding from Defendants, and (k) a brief description of the nature of the illness or injury that was being treated.

2. Please produce all requests for payment sent by Fremont to any of the Defendants during the time period of July 1, 2017 to present.

3. Please produce all Health Insurance Claim Forms sent by Fremont to any of the Defendants during the time period of July 1, 2017 to present.

4. Please produce all Health Insurance Claim Forms that concern the claims that Fremont is asserting in this Action.

5. Please produce all documents showing the partial payments that Fremont has received from Defendants for the claims that Fremont is asserting in this Action.

6. Please produce all documents concerning the medical treatment that Fremont allegedly provided to the more than 10,800 patients referenced in paragraph 25 of the Complaint.

7. Please produce all documents supporting the allegation that "For each of the healthcare claims at issue in this litigation, United HealthCare determined the claim was payable." *See* Complaint at ¶ 27.

8. Please produce all documents supporting the allegation that "Fremont has adequately contested the unsatisfactory rate of payment received from the UH Parties in connection with the claims that are the subject of this action." *See* Complaint at ¶ 30.

9. Please produce all documents supporting the allegation that "the UH Parties have undertaken to pay for such services provided to UH Parties' Patients." *See* Complaint at ¶ 35.

10. Please produce all of "Fremont's bills" that are referenced in paragraph 37 of the Complaint.

11. Please produce all of the "substantially identical claims also submitted by Fremont" that are referenced in paragraph 38 of the Complaint.

12. Please produce all documents supporting the allegation in the Complaint that "the UH Parties generally pay lower reimbursement rates for services provided to members of their fully insured plans and authorize payment at higher reimbursement rates for services provided to

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members of self-insured plans or those plans under which they provide administrator services only." *See* Complaint at ¶ 21.

13. Please produce all documents supporting the allegation in paragraph 55 of the Complaint that the UH Parties acted with "malice, oppression and/or fraud."

14. Please produce all documents showing that Fremont notified any of the Defendants prior to providing medical services to the Defendants' plan members that Fremont expected to be paid by Defendants for the medical services provided to the plan members.

15. Please produce all documents and communications concerning any negotiations between Fremont and any of the Defendants concerning Fremont potentially becoming a participating provider.

16. Please produce all documents and communications concerning the "business discussions" referenced in paragraph 26 of the Complaint.

17. Please produce all communications between Fremont and Defendants concerning that Healthcare Claims that Fremont is asserting in this Action.

18. Please produce all written agreements that have ever been entered into between Fremont and any of the Defendants.

19. Please produce all documents and communications evidencing that Defendants promised to pay Fremont for the Healthcare Claims that Fremont is asserting in this Action.

20. Please produce all documents and communications evidencing any oral agreement between Fremont and Defendants concerning the Healthcare Claims that Fremont is asserting in this Action.

21. Please produce all communications Fremont has had with Defendants concerning the Healthcare Claims that Fremont is asserting in this Action.

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22. Please produce all written agreements with any third parties concerning the Healthcare Claims that Fremont is asserting in this Action.

DATED this 28th day of June, 2019.

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Josephine E. Groh, Esq.
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Attorneys for Defendants UnitedHealthcare Insurance Company, United HealthCare Services, Inc., UMR, Inc., Oxford Health Plans, Inc., Sierra Health and Life Insurance Co., Inc., Sierra Health-Care Options, Inc., and Health Plan of Nevada, Inc.

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RECEIPT OF COPY

RECEIPT OF COPY of **DEFENDANTS' FIRST SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS TO FREMONT** is hereby acknowledged this 28th of June, 2019.

Kristen T. Gallagher/KLC

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Kristen T. Gallagher, Esq.
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EXHIBIT 2

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EXHIBIT 2

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Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation, Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: 2:19-cv-00832-JAD-VCF **FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.'S RESPONSES TO DEFENDANTS' FIRST SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS TO FREMONT**

Fremont Emergency Services (Mandavia), Ltd. ("Fremont") hereby responds to defendants United HealthCare Insurance Company ("UHCIC"), United HealthCare Services, Inc. ("UHS"), UMR, Inc. ("UMR"), Oxford Health Plans, Inc. ("Oxford"), Sierra Health and Life Insurance Company, Inc. ("SHL"), Sierra Health-Care Options, Inc. ("SHO") and Health Plan of Nevada, Inc.'s ("HPN") (collectively "Defendants") First Set of Requests for Production of Documents served to Fremont's counsel pursuant to FRCP 34.

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REQUESTS FOR PRODUCTION OF DOCUMENTS

Request No. 1:

Please provide a list, chart, spreadsheet and/or table showing all the Healthcare Claims that Fremont is asserting in this Action. This document(s) should include, at a minimum, the following information: (a) the patient's name, (b) the patient's date of birth, (c) the patient's social security number, (d) the patient/insured's I.D. number, (e) the patient's account number, (f) the name of the medical provider, (g) the date the medical service was provided, (h) the amount billed by Fremont for the medical service, (i) the amount Defendants paid to Fremont, (j) the additional amount of reimbursement Fremont is demanding from Defendants, and (k) a brief description of the nature of the illness or injury that was being treated.

Response to Request No. 1:

Objection. This Request seeks information that Defendants have in their own files; is not relevant or proportional to the needs of this case because certain subparts have no relevance or bearing on the claims at issue in the litigation (e.g. the nature of the illness or injury that was being treated); and is a request designed to unreasonably further delay these proceedings. By way of further objection, a request for a description of the nature of the illness or injury that was being treated is unduly burdensome in that it would require Fremont to affirmatively prepare descriptions of each injury or illness for thousands of claims. Given the amount at issue in this litigation, the effort required to prepare a report with the information sought by Defendants is not proportional to the needs of the case or the amount in controversy, especially against the backdrop that Fremont has already provided medical coding -- that Defendants accepted and paid upon -- which should provide Defendants with the necessary details to determine the type of injury/illness at issue for each claim.

Subject to and without waiving the foregoing objections, Fremont responds as follows: *See* FESM000011. Fremont further submits that the claims at issue continue to accrue and the list being produced is only for claims in which services were provided on or before April 30, 2019.

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Request No. 2:

Please produce all requests for payment sent by Fremont to any of the Defendants during the time period of July 1, 2017 to present.

Response to Request No. 2:

Objection. The request is vague and ambiguous as to the term "requests for payment". Subject to and without waiving the foregoing objections, Fremont responds as follows: FESM000001-8 (certain portions of these documents have been withheld pending entry of a protective order).

Request No. 3:

Please produce all Health Insurance Claim Forms sent by Fremont to any of the Defendants during the time period of July 1, 2017 to present.

Response to Request No. 3:

Objection. The request is overly broad in that it seeks "all" Health Insurance Claim Forms and is not properly limited to the claims at issue; is irrelevant and not proportional to the needs of the case considering the importance of the issues at stake in the action, the amount in controversy, the parties' equal access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit as this case concerns a dispute over the rate of payment rather than a coverage determination and, consequently, does not concern the medical treatment provided to particular patients. Specifically, the information contained on all Health Insurance Claim Forms ("HCFA Forms") Fremont sent to Defendants during the stated timeline is unrelated to the claims at issue, making such information unimportant to the issues at stake in this action. Furthermore, these HCFA Forms are equally accessible to Defendants and Fremont. Finally, the burden and expense of gathering thousands of HCFA Forms, adequately redacting confidential and information protected by Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and producing this exceedingly large file outweighs any benefit given Defendants' adjudication of the subject claims and payment thereon, although the rate of payment is disputed.

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Request No. 4:

Please produce all Health Insurance Claim Forms that concern the claims that Fremont is asserting in this Action.

Response to Request No. 4:

Objection. The request is overly broad, irrelevant and not proportional to the needs of the case considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit as this case concerns a dispute over the rate of payment rather than a coverage determination and, consequently, does not concern the medical treatment provided to particular patients. In particular, the information contained on the HCFA Forms is unrelated to the claims at issue, making such information unimportant to the issues at stake in this action. Furthermore, these HCFA Forms are equally accessible to Defendants and Fremont. Finally, the burden and expense of gathering thousands of HCFA Forms, adequately redacting confidential and information protected by HIPAA and producing this exceedingly large file outweighs any benefit.

Request No. 5:

Please produce all documents showing the partial payments that Fremont has received from Defendants for the claims that Fremont is asserting in this Action.

Response to Request No. 5:

Objection. This request is vague and ambiguous as to the phrase "partial payments." In addition, the request seeks documents not proportional to the needs of the case considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit. In particular, the payment records of all of the claims are unimportant to the issues at stake in this action because there is no dispute that the Defendants have paid the subject claims at rates which are less than full payment of the billed charges. Furthermore, these documents are

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more accessible to Defendants than Fremont. Finally, the burden and expense of gathering all payment records for thousands of claims which are already in the possession of the Defendants outweighs any benefit to having Fremont produce the same.

Subject to and without waiving the foregoing objections, Fremont responds as follows: *See* FESM000011.

Request No. 6:

Please produce all documents concerning the medical treatment that Fremont allegedly provided to the more than 10,800 patients referenced in paragraph 25 of the Complaint.

Response to Request No. 6:

Objection. The request is overly broad, irrelevant and not proportional to the needs of the case considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit as this case concerns a dispute over the rate of payment rather than a coverage determination and, consequently, does not concern the medical treatment provided to particular patients. In particular, the medical records of the 10,800 patients referenced in paragraph 25 of the Complaint are records unrelated to the dispute at issue, making such information unimportant to the issues at stake in this action. Furthermore, these documents are accessible to Defendants as the treatment concerns Defendants' Members. Finally, the burden and expense of gathering thousands of medical records, adequately redacting confidential and information protected by HIPAA and producing this exceedingly large file outweighs any benefit.

Subject to and without waiving the foregoing objections, Fremont responds as follows: *See* FESM000011.

Request No. 7:

Please produce all documents supporting the allegation that "For each of the healthcare claims at issue in this litigation, United HealthCare determined the claim was payable." *See* Complaint at ¶ 27.

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Response to Request No. 7:

Objection. This request seeks documents not proportional to the needs of the case considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit. In particular, explanation of benefits forms (the "EOBs") (identifying, among other things, the amount and basis for payment) for all of the claims at issue are unimportant to the issues at stake in this action because there is no dispute that the Defendants paid the subject claims at rates which are less than full payment such that Defendants clearly determined that each claim was payable. Furthermore, these documents are more accessible to Defendants than Fremont as Defendants prepared these documents and transmitted them to Fremont. Finally, the burden and expense of gathering all such records for thousands of claims which are already in the possession of the Defendants outweighs any benefit to having Fremont produce the same

Subject to and without waiving the foregoing objections, Fremont responds as follows: *See* FESM000011.

Request No. 8:

Please produce all documents supporting the allegation that "Fremont has adequately contested the unsatisfactory rate of payment received from the UH Parties in connection with the claims that are subject to this action." *See* Complaint at ¶ 30.

Response to Request No. 8:

Fremont responds as follows: Fremont has adequately contested the unsatisfactory rate of payment received from the UH Parties through numerous oral communications between Fremont representatives and UH Parties representatives which will be elicited at trial. In addition, please *see* FESM000001-8.

Request No. 9:

Please produce all documents supporting the allegation that "the UH Parties have undertaken to pay for such services provided to UH Parties' Patients." *See* Complaint at ¶ 35.

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Response to Request No. 9:

Objection. The request is overly broad in that it seeks documents not proportional to the needs of the case considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit. In particular, the payment records of all of the claims are unimportant to the issues at stake in this action because there is no dispute that the Defendants have paid the subject claims at rates which are less than full payment. Furthermore, these documents are more accessible to Defendants than Fremont. Finally, the burden and expense of gathering all payment records for thousands of claims which are already in the possession of the Defendants outweighs any benefit to having Fremont produce the same.

Subject to and without waiving the foregoing objections, Fremont responds as follows: *See* FESM000011.

Request No. 10:

Please produce all "Fremont's bills" that are referenced in paragraph 37 of the Complaint.

Response to Request No. 10:

Objection. The request is overly broad in that it is irrelevant and not proportional to the needs of the case considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit. In particular, the information contained on the HCFA Forms, which is what is being referenced in the Complaint as "Fremont's bills" is unrelated to the claims at issue, making such information unimportant to the issues at stake in this action. These forms need not be produced to establish the amount Fremont charged Defendants for its services. Furthermore, these HCFA Forms are equally accessible to Defendants and Fremont. Finally, the burden and expense of gathering thousands of HCFA Forms, adequately redacting confidential and information protected by HIPAA and producing this exceedingly large file outweighs any benefit.

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Request No. 11:

Please produce all of the "substantially identical claims also submitted by Fremont" that are referenced in paragraph 38 of the Complaint.

Response to Request No. 11:

Fremont responds as follows: FESM000009-11.

Request No. 12:

Please produce all documents supporting the allegation that "the UH Parties generally pay lower reimbursement rates for services provided to members of their fully insured plans and authorize payment at higher reimbursement rates for services provided to members of self-insured plans or those plans under which they provide administrator services only." *See* Complaint at ¶ 21.

Response to Request No. 12:

Fremont responds as follows: *See* FESM000009-12.

Request No. 13:

Please produce all documents supporting the allegations in paragraph 55 of the Complaint that the UH Parties acted with "malice, oppression and/or fraud."

Response to Request No. 13:

Fremont responds as follows: Much of the evidence to support this statement is derived out of oral statements made by Defendants' representatives in communications with Fremont representatives and Fremont's affiliates' representatives. By way of example, some of these statements are set forth in a complaint filed by Fremont's affiliates in United States District Court, Middle District of Pennsylvania, Case No. 19-cv-01195-SHR, FESM000288. Such statements were made by representatives for Defendants and their affiliates. In addition, many of the fraudulent misrepresentations referenced in the Complaint, can be found at Defendants' and Defendants' affiliates' websites, such as https://www.dataisight.com/patient/default.aspx and UHC.com.

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Request No. 14:

Please produce all documents showing that Fremont notified any of the Defendants prior to providing medical services to the Defendants' plan members that Fremont expected to be paid by Defendants for the medical services provided to the plan members.

Response to Request No. 14:

Objection. The request is vague and ambiguous as to the phrase "notified any of the Defendants prior to providing medical services." Subject to and without waiving the foregoing objections, Fremont responds as follows: Pursuant to Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd and NRS 439B.410, Fremont is obligated to provide emergency medical services to any person presenting to an emergency department it staffs and, upon providing such services, Fremont expects and understands, that the Defendants will reimburse Fremont for non-participating claims at rates in accordance with the standards acceptable under Nevada law and in accordance with rates the Defendants pay or have paid for other substantially identical claims also submitted by Fremont to Defendants. *See also* FESM000009-11 and FESM000335-341.

Request No. 15:

Please produce all documents and communications concerning any negotiations between Fremont and any of the Defendants concerning Fremont potentially becoming a participating provider.

Response to Request No. 15:

Objection. The request is vague and ambiguous as to the phrase "potentially becoming a participating provider" and potentially seeks documents protected by the attorney-client privilege and work product doctrine. Subject to and without waiving the foregoing objections, Fremont responds as follows: Numerous communications between representatives for Defendants and representatives for Fremont concerning Fremont's out of network status took place in person. Consequently, these communications will be elicited through testimony at trial. *See* FESM000108-117, FESM000220, FESM000224 and FESM000256. Additional documents responsive to this request will be produced in a rolling production.

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Request No. 16:

Please produce all documents and communications concerning the "business discussions" referenced in paragraph 26 of the Complaint.

Response to Request No. 16:

Objection. The request potentially seeks documents protected by the attorney-client privilege and work product doctrine. Subject to and without waiving the foregoing objections, Fremont responds as follows: Numerous business discussions between representatives for Defendants and representatives for Fremont took place in person. Consequently, these communications will be elicited through testimony at trial. Documents responsive to this request will be produced in a rolling production.

Request No. 17:

Please produce all communication between Fremont and Defendants concerning that Healthcare Claims that Fremont is asserting in this Action.

Response to Request No. 17:

Fremont responds as follows: Fremont has discussed the unsatisfactory rate of payment received from the Defendants through numerous oral communications between Fremont's representatives and Defendants' representatives which will be elicited at trial. In addition, please *see* FESM000001-8.

Request No. 18:

Please produce all written agreements that have ever been entered into between Fremont and any of the Defendants.

Response to Request No. 18:

Objection. The request is overly broad in that it is not limited in time or scope, irrelevant and not proportional to the needs of the case considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit. In particular, the existence of any prior written agreement, entered into years prior to this litigation may be unrelated to the

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claims at issue, making such information unimportant to the issues at stake in this action. Furthermore, these agreements are equally accessible to Defendants and Fremont. Finally, the burden and expense of gathering these agreements outweighs any benefit that would be derived from the same.

Subject to and without waiving the foregoing objections, Fremont responds as follows: FESM000019-107, FESM000118-219, FESM000221-223, FESM000225-255, FESM000257-287.

Request No. 19:

Please produce all documents and communications evidencing that Defendants promised to pay Fremont for the Healthcare Claims that Fremont is asserting in this Action.

Response to Request No. 19:

Objection. The request is vague and ambiguous as to the phrase "promised to pay." Subject to and without waiving the foregoing objections, Fremont responds as follows: Pursuant to Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd and NRS 439B.410, Fremont is obligated to provide emergency medical services to any person presenting to an emergency department it staffs and, upon providing such services, Fremont had an expectation and understanding, that the Defendants would reimburse Fremont for non-participating claims at rates in accordance with the standards acceptable under Nevada law and in accordance with rates the Defendants pay or have paid for other substantially identical claims also submitted by Fremont to Defendants especially because Defendants are required to provide coverage for medically necessary emergency services without any prior authorization requirement. *See e.g.* NRS 695G.170. *See also* FESM000009-10 and FESM000335-341.

Request No. 20:

Please produce all documents and communications evidencing any oral agreement between Fremont and Defendants concerning the Healthcare Claims that Fremont is asserting in this Action.

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Response to Request No. 20:

Fremont responds as follows: Pursuant to Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd and NRS 439B.410, Fremont is obligated to provide emergency medical services to any person presenting to an emergency department it staffs and, upon providing such services, Fremont had an expectation and understanding, that the Defendants would reimburse Fremont for non-participating claims at rates in accordance with the standards acceptable under Nevada law and in accordance with rates the Defendants pay or have paid for other substantially identical claims also submitted by Fremont to Defendants. In addition, based on numerous oral communications, which will be elicited through oral testimony at trial, an implied contract by and between Fremont and Defendants existed which provided that Defendants would pay Fremont for the non-participating claims, at a minimum, based upon the "usual and customary fees in that locality" or the reasonable value of Fremont's professional emergency medicine services. *See also* FESM000009-11 and FESM000335-341.

Request No. 21:

Please produce all communications Fremont has had with Defendants concerning the Healthcare Claims that Fremont is asserting in this Action.

Response to Request No. 21:

Fremont responds as follows: *See* Response to Request No. 17.

Request No. 22:

Please produce all written agreements with any third parties concerning the Healthcare Claims that Fremont is asserting in this Action.

Response to Request No. 22:

Objection. The request is overly broad in that it is not limited in scope, irrelevant and not proportional to the needs of the case considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit. In particular, the existence of any prior written agreement entered into with third parties which has no impact on Defendants'

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obligation to pay the appropriate rate for the Healthcare Claims makes such information unimportant to the issues at stake in this action. Furthermore, the burden and expense of gathering these agreements outweighs any benefit that would be derived from the same.

Subject to and without waiving the foregoing objections, Fremont responds as follows: None.

DATED this 29th day of July, 2019.

McDONALD CARANO LLP

By: /s/ *Kristen T. Gallagher*

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 29th day of July, 2019, I caused a true and correct copy of the foregoing **FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.'S RESPONSES TO DEFENDANTS' FIRST SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS** to be served via U.S. Mail, postage prepaid upon the following:

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Attorneys for Defendants UnitedHealthcare Insurance Company, United HealthCare Services, Inc., UMR, Inc., Oxford Health Plans, Inc., Sierra Health and Life Insurance Co., Inc., Sierra Health-Care Options, Inc., and Health Plan of Nevada, Inc.

/s/ *Karen Surowiec*
An employee of McDonald Carano LLP

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FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.'S RESPONSES TO DEFENDANTS' FIRST SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS TO FREMONT

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EXHIBIT 3

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EXHIBIT 3

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January 23, 2020

VIA ELECTRONIC SERVICE

Kristen T. Gallagher
McDONALD CARANO
2300 W Sahara Ave #1200
Las Vegas, NV 89102

Re: *Fremont Emergency Services, LTD. v UHC, et al.*
Case No.: 2:19-cv-00832-JAD-VCF
Request for Meet and Confer Regarding Fremont's Responses to Defendants' Written Discovery

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Dear Counsel:

This letter addresses the UnitedHealthcare (UHC) Defendants' concerns with Fremont Emergency Services' (Fremont) deficient responses to UHC's written discovery requests, received on July 29, 2019. After you have read UHC's concerns detailed herein, please provide me with your availability to discuss these issues telephonically on or before February 6, 2020. Alternatively, if you believe a written response to these issues would make our eventual meet and confer more productive and narrow the issues, please provide a written response to this letter no later than February 6, 2020.

General Issues

Before addressing specific issues, there a few general issues that warrant mention. A number of Fremont's objections to the requests for production and interrogatories are generalized and, as you know, such general objections are ineffective. Please note that Rules 33(b)(2)(4) and 34(b)(2)(B) provide that objections must be stated with specificity. Boilerplate objections are improper and "tantamount to not making any objection at all." *Kristensen v. Credit Payment Servs., Inc.*, No. 2:12-CV-0528-APG, 2014 WL 6675748, at *4 (D. Nev. Nov. 25, 2014). An objection is boilerplate if it is unexplained or unsupported. *Samsung Elecs. Am. Inc. v. Chung*, 2017 WL 896897, at *9 (N.D. Tex. Mar. 7, 2017); *McLeod, Alexander, Powel & Apffel, P.C. v. Quarles*, 894 F.2d 1482, 1485 (5th Cir. 1990) (holding that simply objecting to requests as "overly broad, burdensome, or oppressive," is inadequate to "voice a successful objection"). We re quest that you supplement your responses by removing these improper boilerplate objections.

As an additional issue, your use of "subject to and without waiving the foregoing objections" creates confusion as to whether any documents or information are being withheld based on the objection. *See Heller v. City of Dallas*, 303 F.R.D. 466, 486-87 (N.D. Tex. 2014) ("Having reflected on it, the Court agrees with judges in this circuit and other jurisdictions that the practice of responding to interrogatories and documents requests 'subject to' and/or 'without waiving' objections is manifestly confusing (at best) and misleading (at worse), and has no basis at all in the Federal Rules of Civil Procedure."). We request that you supplement your responses and clearly state whether any information or documents are being withheld based on your objections.

Finally, a number of Fremont's objections reference an "undue burden" relating to costs that may be incurred in the collection of certain information and documents requested by UHC. An undue burden is "improper unless based on particularized facts." *Caballero v. Bodega Latina Corp.*, No. 217CV00236JADVCF, 2017 WL 3174931, at *5 (D. Nev. July 25, 2017); *Cratty v. City of Wyandotte*, 296 F. Supp. 3d 854, 859 (E.D. Mich. 2017) ("A party objecting to a request for production of documents as burdensome must submit affidavits or other evidence to substantiate its objections."). We request that you supplement your responses with a declaration and/or other evidence setting the particularized facts that support your undue burden objection so that we may better assess it.

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Requests for Production of Documents

Request No. 1:

This request seeks documents pertaining to the Healthcare Claims that Fremont is asserting in this action in an effort to substantiate Plaintiff's claims.

Fremont's response is incomplete. First, Fremont suggests that "[t]his Request seeks information that Defendants have in their own files." However, the onus is not upon UHC to determine the claims that Fremont is asserting; UHC is entitled to this information so that they can conduct discovery accordingly. To the extent that Fremont claims that subpart (k) is not relevant and would impose an undue burden, this boilerplate objection does not suffice to absolve Fremont of its discovery obligations. As Fremont is aware, this litigation is grounded in a "rate of payment" dispute for services provided to UHC members. Thus, the information requested here—a brief and general description of the services provided—is directly relevant to Fremont's claims.

Fremont also contends that the disclosure of this information would impose an undue burden, but has not demonstrated any basis for objecting on this ground. "A party resisting discovery must show how the requested discovery is overly broad, unduly burdensome, or oppressive by submitting affidavits or offering evidence revealing the nature of the burden." *Lopez v. Don Herring Ltd.*, 327 F.R.D. 567, 580 (N.D. Tex. 2018); *see also Merrill v. Waffle House, Inc.*, 227 F.R.D. 475, 477 (N.D. Tex. 2005). Fremont's failure to provide an affidavit or other evidence to support its objection on overbreadth "makes such an unsupported objection nothing more than unsustainable boilerplate." *Heller*, 303 F.R.D. at 490. Accordingly, UHC requests that Fremont provide an estimate of the amount of time it would take to compile the documents at issue in this Request and

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the accompanying costs. Also note that "the Court cannot relieve [a party] of its duty to produce . . . documents merely because [a party] has chosen a means to preserve the evidence which makes ultimate production of relevant documents expensive. *AAB Joint Venture v. United States*, 75 Fed. Cl. 432, 440 (2007).

Finally, the reference to FESM000011 is incomplete and insufficient. Fremont states in its response that "the claims at issue continue to accrue and the list being produced is only for claims in which services were provided on or before April 30, 2019." If Fremont is asserting claims for services provided on or after April 30, 2019, UHC is entitled to an updated and current list. At minimum, the spreadsheet should be updated on a quarterly basis.

Request No. 2:

This request seeks all requests for payment sent by Fremont to any of the Defendants for the limited time period of July 1, 2017 to present.

Fremont has not fully responded, instead asserting an objection to the term "requests for payment" as vague and ambiguous. Beyond this boilerplate objection, Fremont fails to state why this term is unclear so to draw an objection on those grounds. This approach is improper, as "[t]he party objecting to discovery as vague or ambiguous has the burden to show such vagueness or ambiguity." *McCoo v. Denny's Inc.*, 192 F.R.D. 675, 694 (D. Kan. 2000). If Fremont believes that this request is vague, it should have explained exactly why the request is vague in its objection. *Heller*, 303 F.R.D. at 492.

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Notwithstanding Fremont's boilerplate objection, UHC submits that this request seeks any and all requests for reimbursement related to Fremont's provision of emergency medicine services to UHC members: bills, invoices, statements, etc. Specifically, as alleged in Fremont's Complaint at ¶ 37, Fremont references "bills for the emergency medicine services Fremont has provided and continue to provide to UH Parties' Patients." UHC requests that Fremont produce these documents which Fremont alleges were transmitted to UHC, for the period of July 1, 2017 to present.

Request No. 4:

This request seeks all Health Insurance Claim Forms that concern the claims that Fremont is asserting in this action.

Fremont has failed to respond to this request, instead asserting objections to relevance and proportionality. These documents are directly relevant to this case, and contain information that is critical to UHC being able to defend itself. Although Fremont has submitted a spreadsheet of claims, UHC has the right to verify the data contained in the spreadsheet, including the amounts at issue. Moreover, the claim forms are also at a relevant to, among other things, billing/coding issues that may have impacted how claims were reimbursed.

Fremont also contends that the disclosure of this information would impose a burden or expense that outweighs its benefit, but has not demonstrated any basis for objecting on this ground. "A party

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resisting discovery must show how the requested discovery is overly broad, unduly burdensome, or oppressive by submitting affidavits or offering evidence revealing the nature of the burden." *Lopez*, 327 F.R.D. at 580; *see also Merrill*, 227 F.R.D. at 477. Fremont's failure to provide an affidavit or other evidence to support its objection on overbreadth "makes such an unsupported objection nothing more than unsustainable boilerplate." *Heller*, 303 F.R.D. at 490. Accordingly, UHC requests that Fremont provide an estimate of the amount of time and expense it would take to compile the documents at issue in this Request.

Finally, to the extent that Fremont claims that these documents are "equally accessible to Defendants and Fremont," this argument is unavailing. Fremont is in the best position to know what claim forms it contends it submitted and are relevant to the claims it is prosecuting against UHC. Thus, this request is proper.

Request No. 5:

This request seeks documents showing receipt of partial payments for the claims that Fremont is asserting in this action.

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Here again, Fremont lodges boilerplate objections to UHC's request. Specifically, Fremont objects to the use of the term "partial payments" as vague and ambiguous, but fails to state why this term is unclear so to draw an objection on those grounds. This approach is improper, as "[t]he party objecting to discovery as vague or ambiguous has the burden to show such vagueness or ambiguity." *McCoo*, 192 F.R.D. at 694.

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Notwithstanding Fremont's obligation to explain why this is a vague request, UHC clarifies that this request seeks documents that show payments received from UHC to satisfy portions of the claims at issue in this litigation. Although Fremont has submitted a spreadsheet of claims, UHC has the right to verify the data contained in the spreadsheet (i.e. to determine whether Fremont has in fact been paid more on each claim than Fremont asserts).

Fremont also contends that the disclosure of this information would impose a burden or expense that outweighs its benefit, but has not demonstrated any basis for objecting on this ground. Fremont's failure to provide an affidavit or other evidence to support its objection on overbreadth "makes such an unsupported objection nothing more than unsustainable boilerplate." *Heller*, 303 F.R.D. at 490. Accordingly, UHC requests that Fremont provide an estimate of the amount of time and expense it would take to compile the documents at issue in this Request.

Finally, the reference to FESM000011 is incomplete and insufficient. Fremont earlier stated (in response to Request No. 1) that "the claims at issue continue to accrue and the list being produced is only for claims in which services were provided on or before April 30, 2019." If Fremont is asserting claims for services provided on or after April 30, 2019, UHC is entitled to an updated and current list. At minimum, the spreadsheet should be updated on a quarterly basis.

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Request No. 6:

This request seeks documents concerning the medical treatment that Fremont allegedly provided to the patients referenced in paragraph 25 of the Complaint.

Fremont has lodged objections to every one of UHC's requests for records underlying the claims at issue in this litigation, instead referencing a spreadsheet generated by Fremont. The information contained in the spreadsheet is compiled by Plaintiff and is otherwise unverified. UHC has the right to independently verify the data contained in the spreadsheet, which includes the right to review the medical records underlying Fremont's requests for payment. Indeed, as Fremont well knows, the medical records are also at a minimum relevant to billing/coding issues (e.g., whether the medical records substantiate the billed services) that may have impacted how claims were reimbursed.

Fremont also contends that the disclosure of this information would impose a burden or expense that outweighs its benefit, but has not demonstrated any basis for objecting on this ground. Accordingly, UHC requests that Fremont provide an estimate of the amount of time and expense it would take to compile the documents at issue in this Request.

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Finally, the reference to FESM000011 is incomplete and insufficient. Fremont earlier stated (in response to Request No. 1) that "the claims at issue continue to accrue and the list being produced is only for claims in which services were provided on or before April 30, 2019." If Fremont is asserting claims for services provided on or after April 30, 2019, UHC is entitled to an updated and current list. At minimum, the spreadsheet should be updated on a quarterly basis.

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Request No. 10:

This request asks that Fremont produce all of its "bills" referenced in paragraph 37 of its Complaint.

Fremont has failed to respond entirely, instead objecting again to relevance and proportionality. UHC responds that the information requested here is directly referenced in Plaintiff's Complaint. Accordingly, these documents are directly relevant to Plaintiff's claims, and contain information that is critical to UHC being able to conduct discovery. Although Fremont has submitted a spreadsheet of claims, UHC has the right to verify the data contained in the spreadsheet, including the amounts at issue. These documents are also at a relevant to, among other things, billing/coding issues that may have impacted how claims were reimbursed.

Fremont also again contends that the disclosure of this information would impose a burden or expense that outweighs its benefit, but has not demonstrated any basis for objecting on this ground. Fremont's failure to provide an affidavit or other evidence to support its objection on overbreadth makes this another unsupported boilerplate objection. Accordingly, UHC requests that Fremont provide an estimate of the amount of time and expense it would take to compile the documents at issue in this Request.

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Request No. 14:

This request asks that Fremont produce documents showing that Fremont notified any of the Defendants prior to the provision of medical services to the Defendants' plan members that Fremont expected to be paid by Defendants for the services provided to those plan members.

Fremont begins its response by objecting to the use of the phrase "notified any of the Defendants prior to providing medical services" as vague and ambiguous. Again, Fremont fails to state why this phrase is ambiguous so to draw an objection on those grounds. This approach is improper, as "[t]he party objecting to discovery as vague or ambiguous has the burden to show such vagueness or ambiguity." *McCoo*, 192 F.R.D. at 694. If Fremont believes that this request is vague, it should have explained exactly how this request is vague.

Because of the unintelligible objection here, UHC is unable to determine whether or not Fremont is withholding documents. Rule 34 requires that a party state whether it is withholding responsive documents on the basis of any objection. Fed. R. Civ. P. 34(b)(2)(C). *Futreal v. Ringle*, 2019 WL 137587, at *3 (E.D.N.C. Jan. 8, 2019) ("The use of general objections finds scant support in the Federal Rules, which envision individualized, specific objections to requests for production of documents that inform the requesting party whether any documents have been withheld because of the objection."). UHC requests that Fremont supplement its response to this request by removing all boilerplate objections and specifically stating whether it has other documents responsive to the instant Request.

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Request No. 15:

This request seeks documents and communications concerning negotiations between Fremont and any of the Defendants regarding Fremont potentially becoming a participating provider.

Fremont again begins its response by objecting to the use of the phrase "potentially becoming a participating provider" as vague and ambiguous. Again, Fremont fails to state why this phrase is ambiguous so to draw an objection on those grounds. If Fremont believes that this request is vague, it should have explained exactly how this request is vague.

Fremont goes on to object on the basis that UHC is seeking documents protected by the attorney-client privilege, but failed to provide a privilege log or any other information that would enable UHC to determine the applicability of the claimed privilege. "The party invoking the attorney-client privilege or work-product doctrine has the burden of establishing the applicability of such privilege or protection." *In re Pfohl Bros. Landfill Litig.*, 175 F.R.D. 13, 20 (W.D.N.Y. 1997). "Mere conclusory or ipse dixit assertions of privilege are insufficient to satisfy this burden." *Id.*

Because of the unintelligible objection here, UHC is unable to determine whether or not Fremont is withholding documents. Rule 34 requires that a party state whether it is withholding responsive documents on the basis of any objection. FED. R. CIV. P. 34(b)(2)(C). *Futreal*, 2019 WL 137587, at *3 ("The use of general objections finds scant support in the Federal Rules, which envision

individualized, specific objections to requests for production of documents that inform the requesting party whether any documents have been withheld because of the objection."). UHC requests that Fremont specifically state whether it has other documents responsive to the instant Request.

Finally, Fremont offers that additional documents responsive to this request will be produced in a rolling production. Fremont's responses were served nearly six months ago in July of 2019, and there have been no supplements to this Response to date. Please advise when UHC can expect to receive additional responsive documents.

Request No. 16:

This request seeks the production of all documents and communications concerning the "business discussions" referenced in paragraph 26 of Fremont's Complaint.

Fremont begins its response by objecting to this Request on the basis that UHC is seeking documents protected by the attorney-client privilege. Fremont has failed to provide a privilege log or any other information that would enable UHC to determine the applicability of the claimed privilege. "The party invoking the attorney-client privilege or work-product doctrine has the burden of establishing the applicability of such privilege or protection." *In re Pfohl Bros. Landfill Litig.*, 175 F.R.D. at 20. "Mere conclusory or ipse dixit assertions of privilege are insufficient to satisfy this burden." *Id.*

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Because of the Fremont's failure to describe its privilege objection here, UHC is unable to determine whether or not Fremont is withholding documents. Rule 34 requires that a party state whether it is withholding responsive documents on the basis of any objection. FED. R. CIV. P. 34(b)(2)(C). *Futreal*, 2019 WL 137587, at *3 ("The use of general objections finds scant support in the Federal Rules, which envision individualized, specific objections to requests for production of documents that inform the requesting party whether any documents have been withheld because of the objection."). UHC requests that Fremont specifically state whether it has other documents responsive to the instant Request.

Finally, Fremont offers that documents responsive to this request will be produced in a rolling production. Fremont's responses were served nearly six months ago in July of 2019, and there have been no supplements to this Response to date. Please advise when UHC can expect to receive additional responsive documents.

Request No. 18:

This request seeks the production of all written agreements that have ever been entered into between Fremont and any of the Defendants.

Fremont objects to this Request, contending that it is overly broad and disproportionate to the needs of this case, but then references a number of documents that are responsive. Because Fremont's objection is coupled with the production of *some* documents, UHC is unable to determine whether

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or not Fremont is withholding documents. Rule 34 requires that a party state whether it is withholding responsive documents on the basis of any objection. FED. R. CIV. P. 34(b)(2)(C). *Futreal*, 2019 WL 137587, at *3 ("The use of general objections finds scant support in the Federal Rules, which envision individualized, specific objections to requests for production of documents that inform the requesting party whether any documents have been withheld because of the objection."). UHC requests that Fremont specifically state whether it has other documents responsive to the instant Request, and the basis for withholding any other documents (whether it be related to issues of time and scope, or burden in compiling said documents).

Request No. 19:

This request seeks documents and communications evidencing that Defendants promised to pay Fremont for the Healthcare Claims that Fremont is asserting.

Fremont begins its response by objecting to the use of the phrase "promised to pay" as vague and ambiguous. Again, Fremont fails to state why this phrase is ambiguous so to draw an objection on those grounds.

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Moreover, Although Fremont has objected to vagueness, it goes on to reference a number of documents that are responsive (i.e. essentially admitting that its vagueness objection is boilerplate and without merit). Again, UHC is unable to determine whether or not Fremont is in possession of other responsive documents that it is withholding on the basis of its objection. Rule 34 requires that a party state whether it is withholding responsive documents on the basis of any objection. FED. R. CIV. P. 34(b)(2)(C). UHC requests that Fremont specifically state whether it has other documents responsive to the instant Request.

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Interrogatories

Interrogatory No. 1:

This Interrogatory seeks identification and a description of all of the Healthcare Claims that Fremont contends it is asserting in this action.

In Response, Fremont suggests that "[t]his Interrogatory seeks information that is already in UnitedHealthcare's possession." However, UHC is not the plaintiff in this case, and itself has no independent knowledge as to which specific claims Fremont is asserting in this action. Put another way, the onus is not upon UHC to somehow determine the claims that Fremont is asserting. Fremont makes no effort to describe with any particularity where the information sought by this Interrogatory can be found.

In the event that Fremont is relying upon FESM000011, this does not satisfy the entirety of UHC's request. Namely, FESM000011 does not satisfy subpart (k) of this Interrogatory. As Fremont is aware, this litigation is grounded in a "rate of payment" dispute for services provided to UHC members. Thus, the information requested by subpart (k)—a brief and general description of the services provided—is directly relevant to Fremont's claims.

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Finally, Fremont states in its response that "the claims at issue continue to accrue and the list being produced is only for claims in which services were provided on or before April 30, 2019." If Fremont is asserting claims for services provided on or after April 30, 2019, UHC is entitled to an updated and current list. At minimum, the spreadsheet should be updated on a quarterly basis.

Interrogatory No. 4:

This Interrogatory seeks the identification of any individual(s) who made an oral promise or commitment to reimburse Fremont at a particular rate for the Healthcare Claims that Fremont is asserting. The Interrogatory also seeks the name of any individuals to whom any oral promise or commitment was made, and a detailed description of the nature of the oral promise or commitment.

Fremont begins its response by objecting to the use of the phrase "oral promise/commitment" as vague and ambiguous. Again, Fremont fails to state why this phrase is ambiguous so to draw an objection on those grounds. This approach is improper, as "[t]he party objecting to discovery as vague or ambiguous has the burden to show such vagueness or ambiguity." *McCoo*, 192 F.R.D. at 694. If Fremont believes that this request is vague, it should have explained exactly how the request is vague in its objection. UHC nevertheless refers Fremont to ¶ 269 of its First Amended Complaint, which alleges that "[s]ince at least January 2019, the Defendants, have been and continue to be, engaged in preparations and implementation of a scheme to defraud the Health Care Providers by committing a series of unlawful acts designed to obtain a financial benefit by means of false or fraudulent **pretenses, representations, promises or material omissions**." (emphasis added).

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Moreover, although Fremont has objected to vagueness, it goes on to reference a number of documents that are responsive (i.e. essentially admitting that its vagueness objection is boilerplate and without merit). However, Fremont has failed to name any individual(s) who allegedly made any oral promise(s) or commitment(s). If there are no such individuals, UHC requests that Fremont respond accordingly.

Requests for Admissions

Request No. 1:

This Request asks Fremont to "Admit that, for all for of the Healthcare Claims that Fremont is asserting in this Action, Fremont received an assignment of benefits from Defendants' plan members."

Fremont begins its response by objecting to the question as "not relevant to the claims asserted in the Complaint because Fremont does not bring any of its claims on the basis of assignment of benefits." It then goes on to object on the basis that "the request is clearly aimed at trying to support Defendants' argument that complete ERISA preemption exists. . . ."

As an initial matter, this Request is relevant to the claims asserted as it directly involves one of UHC's defenses. In support of this, UHC would point to the fact the Fremont's second objection is

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based on the fact that the Request is "aimed at supporting Defendants' argument regarding ERISA preemption." This is not a proper basis for an objection; a party cannot object to a request for admission because the response would lend support to the requesting party's defense.

Additionally, Fremont goes on to object on the basis that "whether a valid and enforceable assignment of benefits exists" calls for a legal conclusion. Responding to this contention, UHC first points out that this Request does not ask if a "valid and enforceable assignment of benefits exists," it only asks if "Fremont received an assignment of benefits from Defendants' plan members." Secondly, UHC has not asked for a legal conclusion here. However, even if it had, requests which involve mixed questions of law and fact are clearly contemplated by Rule 36. *See* FED. R. CIV. P. 36; *Carter v. Pathfinder Energy*, 2010 WL 11530609, at *2 (D. Wyo. Mar. 16, 2010). UHC therefore requests that Fremont admit or deny the instant request as stated.

Request No. 4:

This Request asks Fremont to "Admit that Fremont never notified any of the Defendants orally or in writing prior to providing medical services to the Defendants' plan members that Fremont expected to be paid by Defendants for the medical services provided to the plan members."
Fremont begins its response by objecting to the use of the term "notified" as vague and ambiguous. Again, Fremont fails to state why this term is ambiguous so to draw an objection on those grounds. If Fremont believes that this request is vague, it should have explained exactly what it is vague in its objection.

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Fremont's response goes on to indicate that it admits that "federal and state law requires it to provide emergency services without determining whether coverage exists." However, Fremont does not admit or deny UHC's Request as written. UHC requests that Fremont supplement its response and respond admit or deny.

Request No. 6:

This Request asks Fremont to "Admit that for at least one of the Healthcare Claims that Fremont is asserting in this Action, the plan member that Fremont treated has an employer provided/sponsored health insurance plan."

Here again, Fremont begins its response by objecting to the use of the phrase "employer provided/sponsored health insurance plan" as vague and ambiguous. Fremont fails to state why this phrase is ambiguous so to draw an objection on those grounds. If Fremont believes that this request is vague, it should have explained exactly what it is vague in its objection. Moreover, we find it difficult to imagine that Fremont does not understand what an employer sponsored insurance plan is.

Fremont goes on to object on the basis that "the request is clearly aimed at trying to support Defendants' argument that complete ERISA preemption exists. . . ." There is no basis for this objection under Rule 36; a party cannot object to a request for admission simply because the

response would lend support to the requesting party's defense. Further, to the extent that Fremont contends that this Request seeks a legal conclusion, a review of the Request itself reveals this is not the case. In any case, requests which involve mixed questions of law and fact are clearly contemplated by Rule 36. *See* Fed. R. Civ. P. 36; *Carter v. Pathfinder Energy*, 2010 WL 11530609, at *2 (D. Wyo. Mar. 16, 2010). UHC therefore requests that Fremont admit or deny the instant request as stated.

Finally, to the extent that Fremont offers that "Defendants' counsel . . . stated to Fremont's counsel that Fremont would likely not have this type of information," it is unclear whether Fremont truly does not possess information to enable it to admit or deny the request. If Fremont truly does not possess sufficient information to respond to this Request, "[t]he answering party may assert lack of knowledge or information as a reason for failing to admit or deny only if the party states that it has made reasonable inquiry and that the information it knows or can readily obtain is insufficient to enable it to admit or deny." Fed. R. Civ. P. 36.

I look forward to discussing these issues with you. Please let me know if you have any questions or if you have any case law you want me to consider prior to our conference. I am hopeful that we can resolve these issues without resorting to court intervention.

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Regards,

WEINBERG WHEELER HUDGINS
GUNN & DIAL LLC

/s/ Colby Balkenbush

Colby L. Balkenbush

EXHIBIT 4

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EXHIBIT 4

002055

From: Balkenbush, Colby
To: Bonney, Audra R.
Subject: FW: Fremont v UHC - Request for Meet and Confer
Date: Friday, September 18, 2020 11:01:22 AM
Attachments: image001.png
REVISEE-sig2020_5801a862-4942-4e3a-94ab-425c0ea8e329.png

WEINBERG WHEELER HUDGINS GUNN & DIAL
TRIAL LAWYERS

LITIGATION DEPARTMENT OF THE YEAR ALM'S DAILY REPORT
2020 - 2019 - 2018 - 2017 - 2016 - 2014

Colby Balkenbush, Attorney

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From: Llewellyn, Brittany M.
Sent: Thursday, February 13, 2020 2:56 PM
To: 'Kristen T. Gallagher'
Cc: Pat Lundvall; Amanda Perach; Balkenbush, Colby; Bowman, Cindy S.; Roberts, Lee
Subject: RE: Fremont v UHC - Request for Meet and Confer

Kristen,

Thank you for taking the time to speak with us today regarding your client's responses to Defendants' first set of written discovery requests. This email is intended to address the parties' agreements as to each of the requests, and also provides clarification as to Defendants' positions as requested:

Requests for Production of Documents

-

1. The parties have agreed to table discussions as to Requests numbered 1, 2, 4, 5, and 10, pending our client's review of Plaintiffs' discovery proposal. We will suspend follow-up on these requests until such time as Defendants have had an opportunity to evaluate this proposal and/or Plaintiffs have had an opportunity to review and evaluate any counter-proposal.

2. For Requests numbered 14, 16, 18, and 19, we have asked that Fremont supplement its responses to affirmatively state whether it is withholding any documents subject to its objections. You asked that we provide legal authority in support of Defendants' position. Defendants respond that Fed. R. Civ. P. 34 codifies Fremont's obligation to "state whether any responsive materials are being withheld on the basis of [its] objection." Fed. R. Civ. P. 34(b)(2)(C). Please also note the following recent D. Nev. Order from U.S. Mag. Judge Ferenbach addressing this issue:

> A party objecting to a request for production must state its objection with specificity. *See*

Fed. R. Civ. P. 34(b)(2)(B) ("For each item or category, the response must ... state with specificity the grounds for objecting to the request, including the reasons."), (b)(2)(C) ("An objection must state whether any responsive materials are being withheld on the basis of that objection. An objection to part of a request must specify the part and permit inspection of the rest."); *see also* Fischer, 2017 WL 773694, at *1 ("responses to discovery requests must: [1] State grounds for objections with specificity; [2] An objection must state whether any responsive materials are being withheld on the basis of that objection; and [3] Specify the time for production and, if a rolling production, when production will begin and when it will be concluded.").

Caballero v. Bodega Latina Corp., 2017 WL 3174931, at *5 (D. Nev. July 25, 2017).

3. Fremont will be supplementing Requests numbered 15 and 16, with a target date of February 28th for this supplement. Defendants request that the "rolling production" referenced in Fremont's responses be done on a regular basis so that Defendants need not meet and confer on these requests again in the future.

4. Defendants will be filing a motion to compel Fremont's response to Request for Production No. 6.

Interrogatories

1. The parties have agreed to table discussions as to Interrogatory No. 1, pending our client's review of Plaintiffs' discovery proposal. We will suspend follow-up on this interrogatory until such time as Defendants have had an opportunity to evaluate this proposal and/or Plaintiffs have had an opportunity to review and evaluate any counter-proposal.

2. Defendants will be filing a motion to compel Fremont's response to Interrogatory No. 4.

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Requests for Admissions

1. Fremont has requested additional time to evaluate its responses to Requests for Admissions numbered 1, 4, and 6. Fremont agrees to notify Defendants by 2/20 whether it will supplement these responses or stand on its objections as stated.

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Thank you,

Brittany

Brittany M. Llewellyn, Attorney
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From: Kristen T. Gallagher [mailto:kgallagher@mcdonaldcarano.com]
Sent: Thursday, February 06, 2020 2:29 PM
To: Bowman, Cindy S.
Cc: Pat Lundvall; Amanda Perach; Roberts, Lee; Balkenbush, Colby; Llewellyn, Brittany M.
Subject: RE: Fremont v UHC - Request for Meet and Confer

This Message originated outside your organization.

Colby –

Per your request, I can discuss Fremont's responses to written discovery on Thursday, February 13. How is 10:30 am for you?

Kristen T. Gallagher | Partner
McDONALD CARANO
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From: Bowman, Cindy S. <CBowman@wwhgd.com>
Sent: Thursday, January 23, 2020 4:01 PM
To: Kristen T. Gallagher <kgallagher@mcdonaldcarano.com>
Cc: Pat Lundvall <plundvall@mcdonaldcarano.com>; Amanda Perach <aperach@mcdonaldcarano.com>; Roberts, Lee <LRoberts@wwhgd.com>; Balkenbush, Colby <CBalkenbush@wwhgd.com>; Llewellyn, Brittany M. <BLlewellyn@wwhgd.com>
Subject: FW: Fremont v UHC - Request for Meet and Confer

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Please see revised correspondence. A response is requested by February 6.

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Thank you,
Cindy

WEINBERG WHEELER HUDGINS GUNN & DIAL
TRIAL LAWYERS

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From: Bowman, Cindy S.
Sent: Thursday, January 23, 2020 3:43 PM
To: 'kgallagher@mcdonaldcarano.com'
Cc: 'plundvall@mcdonaldcarano.com'; 'aperach@mcdonaldcarano.com'; Roberts, Lee; Balkenbush, Colby; Llewellyn, Brittany M.
Subject: Fremont v UHC - Request for Meet and Confer

Please see attached correspondence from Colby Balkenbush.

Thank you,

Cindy

The information contained in this message may contain privileged client confidential information. If you have received this message in error, please delete it and any copies immediately.

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EXHIBIT 5

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EXHIBIT 5

Electronically Filed
9/11/2020 2:29 PM
Steven D. Grierson
CLERK OF THE COURT

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DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA) LTD., Plaintiff(s), vs. UNITED HEALTHCARE INSURANCE COMPANY, Defendant(s).	CASE NO: A-19-792978-B DEPT. XXVII

BEFORE THE HONORABLE NANCY ALLF, DISTRICT COURT JUDGE

WEDNESDAY, SEPTEMBER 9, 2020

RECORDER'S TRANSCRIPT OF PROCEEDINGS
RE: PENDING MOTIONS

APPEARANCES (VIA VIDEO CONFERENCE):

For the Plaintiff(s): PATRICIA K. LUNDVALL, ESQ.
AMANDA PERACH, ESQ.

For the Defendant(s): D. LEE ROBERTS JR., ESQ.
COLBY L. BALKENBUSH, ESQ.

RECORDED BY: BRYNN WHITE, COURT RECORDER

information. And that's why the HIPAA issues do not need to be specially accounted for or a special redaction then for that issue.

THE COURT: My last question is: They say in their opposition that you already have EOBs, appeal stocks, and the administrative record.

MS. LUNDVALL: And we had offered, Your Honor, to them to be able to remove those or to remove that information. The EOBs in particular and -- let me -- there were two pieces that we had offered them to say that we -- they did not need to provide. The two pieces that we had offered that they did not need to provide because -- that we were already in receipt of is the EOBs, the member explanation of benefits, and then the provider remittance advices, or was referred to as PRAs. And so those were the two that, in fact, we had offered and they had rejected that offer then from us.

THE COURT: Thank you.

And I'm ready to hear the opposition, please, Mr. Roberts.

MR. ROBERTS: Thank you, Your Honor.

I'd like to start out by pointing out that there is not a sufficient record before this Court where you could base your decision on the Motion to Compel on an argument that United is trying to put these providers out of business and that if somehow United is able to continue with this litigation, that it's going to drive these providers -- that they don't have the money, that they're going to be run into the ground. A footnote, page 8, we noted the TeamHealth Holdings is a subsidiary of Blackstone, which has

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try --

THE COURT: (Indiscernible).

MS. LUNDVALL: -- to confer is that the parties, both sides, still have a duty and an obligation to move forward with their discovery obligations, and they can't just sit back on their hands then and wait until there's been some type of a protocol that's been negotiated before having to tender then their responsive documents.

THE COURT: That is correct, Ms. Lundvall.

MS. LUNDVALL: Thank you, Your Honor.

THE COURT: And I do -- and then if you guys have Motions to Compel on either side, because I heard it from both sides, I would consider those also on the 30th.

MS. LUNDVALL: Thank you, Your Honor.

THE COURT: We might as well just tackle this.

MS. LUNDVALL: We appreciate that very much, Your Honor.

THE COURT: All right. So does -- do either of you have any questions or anything further to say before we adjourn for today? No?

MS. LUNDVALL: Not today, Your Honor.

THE COURT: Until I see you next, everybody stay safe and stay healthy.

MR. ROBERTS: Not from United. Thank you for all your time, Your Honor. We appreciate your indulgence and how much time you give us.

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MS. LUNDVALL: Thank you very much.

MR. BALKENBUSH: Thank you, Your Honor.

[Proceedings adjourned at 3:26 p.m.]

* * * * * * * *

ATTEST: I do hereby certify that I have truly and correctly transcribed the audio/video proceedings in the above-entitled case to the best of my ability.

Shannon Day
Independent Transcriber

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EXHIBIT 6

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EXHIBIT 6

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SUPPL
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KRISTEN T. GALLAGHER (NSBN 9561)
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Attorneys for Plaintiffs

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs, vs. UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: A-19-792978-B Dept. No.: XXVII **PLAINTIFFS' FIRST SUPPLEMENT TO RESPONSES TO DEFENDANTS' FIRST SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS TO FREMONT**

Pursuant to the Order entered on May 15, 2020, Fremont Emergency Services (Mandavia), Ltd. ("Fremont") Team Physicians of Nevada-Mandavia, P.C. ("Team Physicians"); Crum,

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Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine ("Ruby Crest") (collectively, "Plaintiffs" or "Health Care Providers") supplement Responses No. 15 and 16 (**in bold**) to the First Set of Requests for Production of Documents served by defendants HealthCare Insurance Company ("UHCIC"), United HealthCare Services, Inc. ("UHS"), UMR, Inc. ("UMR"), Oxford Health Plans, Inc. ("Oxford"), Sierra Health and Life Insurance Company, Inc. ("SHL"), Sierra Health-Care Options, Inc. ("SHO") and Health Plan of Nevada, Inc.'s ("HPN") (collectively "Defendants").[1] Additionally, the Health Care Providers supplement Responses to Nos. 1, 5, 6, 7 and 9.

REQUESTS FOR PRODUCTION OF DOCUMENTS

Request No. 1:

Please provide a list, chart, spreadsheet and/or table showing all the Healthcare Claims that Fremont is asserting in this Action. This document(s) should include, at a minimum, the following information: (a) the patient's name, (b) the patient's date of birth, (c) the patient's social security number, (d) the patient/insured's I.D. number, (e) the patient's account number, (f) the name of the medical provider, (g) the date the medical service was provided, (h) the amount billed by Fremont for the medical service, (i) the amount Defendants paid to Fremont, (j) the additional amount of reimbursement Fremont is demanding from Defendants, and (k) a brief description of the nature of the illness or injury that was being treated.

Response to Request No. 1:

Objection. This Request seeks information that Defendants have in their own files; is not relevant or proportional to the needs of this case because certain subparts have no relevance or bearing on the claims at issue in the litigation (e.g. the nature of the illness or injury that was being treated); and is a request designed to unreasonably further delay these proceedings. By way of further objection, a request for a description of the nature of the illness or injury that was being treated is unduly burdensome in that it would require Fremont to affirmatively prepare descriptions of each injury or illness for thousands of claims. Given the amount at issue in this

[1] UnitedHealth Group, Inc. is also a defendant in this action, but was not a party at the time Defendants' served these written discovery requests.

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litigation, the effort required to prepare a report with the information sought by Defendants is not proportional to the needs of the case or the amount in controversy, especially against the backdrop that Fremont has already provided medical coding -- that Defendants accepted and paid upon -- which should provide Defendants with the necessary details to determine the type of injury/illness at issue for each claim.

Subject to and without waiving the foregoing objections, Fremont responds as follows: *See* FESM000011. Fremont further submits that the claims at issue continue to accrue and the list being produced is only for claims in which services were provided on or before April 30, 2019.

Supplement to Response No. 1: Subject to the foregoing objections, *see* FESM00344.

Request No. 2:

Please produce all requests for payment sent by Fremont to any of the Defendants during the time period of July 1, 2017 to present.

Response to Request No. 2:

Objection. The request is vague and ambiguous as to the term "requests for payment". Subject to and without waiving the foregoing objections, Fremont responds as follows: FESM000001-8 (certain portions of these documents have been withheld pending entry of a protective order).

Request No. 3:

Please produce all Health Insurance Claim Forms sent by Fremont to any of the Defendants during the time period of July 1, 2017 to present.

Response to Request No. 3:

Objection. The request is overly broad in that it seeks "all" Health Insurance Claim Forms and is not properly limited to the claims at issue; is irrelevant and not proportional to the needs of the case considering the importance of the issues at stake in the action, the amount in controversy, the parties' equal access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit as this case concerns a dispute over the rate of payment rather than a coverage determination and, consequently, does not concern the medical treatment provided to

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particular patients. Specifically, the information contained on all Health Insurance Claim Forms ("HCFA Forms") Fremont sent to Defendants during the stated timeline is unrelated to the claims at issue, making such information unimportant to the issues at stake in this action. Furthermore, these HCFA Forms are equally accessible to Defendants and Fremont. Finally, the burden and expense of gathering thousands of HCFA Forms, adequately redacting confidential and information protected by Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and producing this exceedingly large file outweighs any benefit given Defendants' adjudication of the subject claims and payment thereon, although the rate of payment is disputed.

Request No. 4:

Please produce all Health Insurance Claim Forms that concern the claims that Fremont is asserting in this Action.

Response to Request No. 4:

Objection. The request is overly broad, irrelevant and not proportional to the needs of the case considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit as this case concerns a dispute over the rate of payment rather than a coverage determination and, consequently, does not concern the medical treatment provided to particular patients. In particular, the information contained on the HCFA Forms is unrelated to the claims at issue, making such information unimportant to the issues at stake in this action. Furthermore, these HCFA Forms are equally accessible to Defendants and Fremont. Finally, the burden and expense of gathering thousands of HCFA Forms, adequately redacting confidential and information protected by HIPAA and producing this exceedingly large file outweighs any benefit.

Request No. 5:

Please produce all documents showing the partial payments that Fremont has received from Defendants for the claims that Fremont is asserting in this Action.

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Response to Request No. 5:

Objection. This request is vague and ambiguous as to the phrase "partial payments." In addition, the request seeks documents not proportional to the needs of the case considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit. In particular, the payment records of all of the claims are unimportant to the issues at stake in this action because there is no dispute that the Defendants have paid the subject claims at rates which are less than full payment of the billed charges. Furthermore, these documents are more accessible to Defendants than Fremont. Finally, the burden and expense of gathering all payment records for thousands of claims which are already in the possession of the Defendants outweighs any benefit to having Fremont produce the same.

Subject to and without waiving the foregoing objections, Fremont responds as follows: *See* FESM000011.

Supplement to Response No. 5: Subject to the foregoing objections, *see* FESM00344.

Request No. 6:

Please produce all documents concerning the medical treatment that Fremont allegedly provided to the more than 10,800 patients referenced in paragraph 25 of the Complaint.

Response to Request No. 6:

Objection. The request is overly broad, irrelevant and not proportional to the needs of the case considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit as this case concerns a dispute over the rate of payment rather than a coverage determination and, consequently, does not concern the medical treatment provided to particular patients. In particular, the medical records of the 10,800 patients referenced in paragraph 25 of the Complaint are records unrelated to the dispute at issue, making such information unimportant to the issues at stake in this action. Furthermore, these documents are

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accessible to Defendants as the treatment concerns Defendants' Members. Finally, the burden and expense of gathering thousands of medical records, adequately redacting confidential and information protected by HIPAA and producing this exceedingly large file outweighs any benefit.

Subject to and without waiving the foregoing objections, Fremont responds as follows: *See* FESM000011.

Supplement to Response No. 6: Subject to the foregoing objections, *see* FESM00344.

Request No. 7:

Please produce all documents supporting the allegation that "For each of the healthcare claims at issue in this litigation, United HealthCare determined the claim was payable." *See* Complaint at ¶ 27.

Response to Request No. 7:

Objection. This request seeks documents not proportional to the needs of the case considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit. In particular, explanation of benefits forms (the "EOBs") (identifying, among other things, the amount and basis for payment) for all of the claims at issue are unimportant to the issues at stake in this action because there is no dispute that the Defendants paid the subject claims at rates which are less than full payment such that Defendants clearly determined that each claim was payable. Furthermore, these documents are more accessible to Defendants than Fremont as Defendants prepared these documents and transmitted them to Fremont. Finally, the burden and expense of gathering all such records for thousands of claims which are already in the possession of the Defendants outweighs any benefit to having Fremont produce the same

Subject to and without waiving the foregoing objections, Fremont responds as follows: *See* FESM000011.

Supplement to Response No. 7: Subject to the foregoing objections, *see* FESM00344.

Request No. 8:

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Please produce all documents supporting the allegation that "Fremont has adequately contested the unsatisfactory rate of payment received from the UH Parties in connection with the claims that are subject to this action." *See* Complaint at ¶ 30.

Response to Request No. 8:

Fremont responds as follows: Fremont has adequately contested the unsatisfactory rate of payment received from the UH Parties through numerous oral communications between Fremont representatives and UH Parties representatives which will be elicited at trial. In addition, please *see* FESM000001-8.

Request No. 9:

Please produce all documents supporting the allegation that "the UH Parties have undertaken to pay for such services provided to UH Parties' Patients." *See* Complaint at ¶ 35.

Response to Request No. 9:

Objection. The request is overly broad in that it seeks documents not proportional to the needs of the case considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit. In particular, the payment records of all of the claims are unimportant to the issues at stake in this action because there is no dispute that the Defendants have paid the subject claims at rates which are less than full payment. Furthermore, these documents are more accessible to Defendants than Fremont. Finally, the burden and expense of gathering all payment records for thousands of claims which are already in the possession of the Defendants outweighs any benefit to having Fremont produce the same.

Subject to and without waiving the foregoing objections, Fremont responds as follows: *See* FESM000011.

Supplement to Response No. 9: Subject to the foregoing objections, *see* FESM00344.

Request No. 10:

Please produce all "Fremont's bills" that are referenced in paragraph 37 of the Complaint.

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Response to Request No. 10:

Objection. The request is overly broad in that it is irrelevant and not proportional to the needs of the case considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit. In particular, the information contained on the HCFA Forms, which is what is being referenced in the Complaint as "Fremont's bills" is unrelated to the claims at issue, making such information unimportant to the issues at stake in this action. These forms need not be produced to establish the amount Fremont charged Defendants for its services. Furthermore, these HCFA Forms are equally accessible to Defendants and Fremont. Finally, the burden and expense of gathering thousands of HCFA Forms, adequately redacting confidential and information protected by HIPAA and producing this exceedingly large file outweighs any benefit.

Request No. 11:

Please produce all of the "substantially identical claims also submitted by Fremont" that are referenced in paragraph 38 of the Complaint.

Response to Request No. 11:

Fremont responds as follows: FESM000009-11.

Request No. 12:

Please produce all documents supporting the allegation that "the UH Parties generally pay lower reimbursement rates for services provided to members of their fully insured plans and authorize payment at higher reimbursement rates for services provided to members of self-insured plans or those plans under which they provide administrator services only." *See* Complaint at ¶ 21.

Response to Request No. 12:

Fremont responds as follows: *See* FESM000009-12.

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Request No. 13:

Please produce all documents supporting the allegations in paragraph 55 of the Complaint that the UH Parties acted with "malice, oppression and/or fraud."

Response to Request No. 13:

Fremont responds as follows: Much of the evidence to support this statement is derived out of oral statements made by Defendants' representatives in communications with Fremont representatives and Fremont's affiliates' representatives. By way of example, some of these statements are set forth in a complaint filed by Fremont's affiliates in United States District Court, Middle District of Pennsylvania, Case No. 19-cv-01195-SHR, FESM000288. Such statements were made by representatives for Defendants and their affiliates. In addition, many of the fraudulent misrepresentations referenced in the Complaint, can be found at Defendants' and Defendants' affiliates' websites, such as https://www.dataisight.com/patient/default.aspx and UHC.com.

Request No. 14:

Please produce all documents showing that Fremont notified any of the Defendants prior to providing medical services to the Defendants' plan members that Fremont expected to be paid by Defendants for the medical services provided to the plan members.

Response to Request No. 14:

Objection. The request is vague and ambiguous as to the phrase "notified any of the Defendants prior to providing medical services." Subject to and without waiving the foregoing objections, Fremont responds as follows: Pursuant to Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd and NRS 439B.410, Fremont is obligated to provide emergency medical services to any person presenting to an emergency department it staffs and, upon providing such services, Fremont expects and understands, that the Defendants will reimburse Fremont for non-participating claims at rates in accordance with the standards acceptable under Nevada law and in accordance with rates the Defendants pay or have paid for other substantially identical claims also submitted by Fremont to Defendants. *See also* FESM000009-11 and FESM000335-341.

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Request No. 15:

Please produce all documents and communications concerning any negotiations between Fremont and any of the Defendants concerning Fremont potentially becoming a participating provider.

Response to Request No. 15:

Objection. The request is vague and ambiguous as to the phrase "potentially becoming a participating provider" and potentially seeks documents protected by the attorney-client privilege and work product doctrine. Subject to and without waiving the foregoing objections, Fremont responds as follows: Numerous communications between representatives for Defendants and representatives for Fremont concerning Fremont's out of network status took place in person. Consequently, these communications will be elicited through testimony at trial. *See* FESM000108-117, FESM000220, FESM000224 and FESM000256. Additional documents responsive to this request will be produced in a rolling production.

Supplement to Response No. 15: **Subject to the foregoing objections, the Health Care Providers further object on the basis that the request provides no timeframe. By way of further response, *see* FESM00356 - FESM01381.**

Request No. 16:

Please produce all documents and communications concerning the "business discussions" referenced in paragraph 26 of the Complaint.

Response to Request No. 16:

Objection. The request potentially seeks documents protected by the attorney-client privilege and work product doctrine. Subject to and without waiving the foregoing objections, Fremont responds as follows: Numerous business discussions between representatives for Defendants and representatives for Fremont took place in person. Consequently, these communications will be elicited through testimony at trial. Documents responsive to this request will be produced in a rolling production.

Supplement to Response No. 16: **Subject to the foregoing objections, the Health Care Providers further respond that Paragraph 26 of the Complaint (Paragraph 65 of the First**

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Amended Complaint) describes an internal program designed and implemented by United to "coerce, influence and leverage business discussions with the Health Care Providers to become a participating provider at significantly reduced rates, as well as to unfairly and illegally profit from a manipulation of payment rates." The nature of these allegations makes it clear that evidence of United's program is information in the care, custody and possession of United and other third parties and not the Health Care Providers. By way of further response, *see* FESM00710-FESM01381. Discovery is ongoing and the Health Care Providers reserve their right to supplement this request as required under the Nevada Rules of Civil Procedure.

Request No. 17:

Please produce all communication between Fremont and Defendants concerning that Healthcare Claims that Fremont is asserting in this Action.

Response to Request No. 17:

Fremont responds as follows: Fremont has discussed the unsatisfactory rate of payment received from the Defendants through numerous oral communications between Fremont's representatives and Defendants' representatives which will be elicited at trial. In addition, please *see* FESM000001-8.

Request No. 18:

Please produce all written agreements that have ever been entered into between Fremont and any of the Defendants.

Response to Request No. 18:

Objection. The request is overly broad in that it is not limited in time or scope, irrelevant and not proportional to the needs of the case considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit. In particular, the existence of any prior written agreement, entered into years prior to this litigation may be unrelated to the claims at issue, making such information unimportant to the issues at stake in this action.

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Furthermore, these agreements are equally accessible to Defendants and Fremont. Finally, the burden and expense of gathering these agreements outweighs any benefit that would be derived from the same.

Subject to and without waiving the foregoing objections, Fremont responds as follows: FESM000019-107, FESM000118-219, FESM000221-223, FESM000225-255, FESM000257-287.

Request No. 19:

Please produce all documents and communications evidencing that Defendants promised to pay Fremont for the Healthcare Claims that Fremont is asserting in this Action.

Response to Request No. 19:

Objection. The request is vague and ambiguous as to the phrase "promised to pay." Subject to and without waiving the foregoing objections, Fremont responds as follows: Pursuant to Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd and NRS 439B.410, Fremont is obligated to provide emergency medical services to any person presenting to an emergency department it staffs and, upon providing such services, Fremont had an expectation and understanding, that the Defendants would reimburse Fremont for non-participating claims at rates in accordance with the standards acceptable under Nevada law and in accordance with rates the Defendants pay or have paid for other substantially identical claims also submitted by Fremont to Defendants especially because Defendants are required to provide coverage for medically necessary emergency services without any prior authorization requirement. *See e.g.* NRS 695G.170. *See also* FESM000009-10 and FESM000335-341.

Request No. 20:

Please produce all documents and communications evidencing any oral agreement between Fremont and Defendants concerning the Healthcare Claims that Fremont is asserting in this Action.

Response to Request No. 20:

Fremont responds as follows: Pursuant to Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd and NRS 439B.410, Fremont is obligated to provide

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emergency medical services to any person presenting to an emergency department it staffs and, upon providing such services, Fremont had an expectation and understanding, that the Defendants would reimburse Fremont for non-participating claims at rates in accordance with the standards acceptable under Nevada law and in accordance with rates the Defendants pay or have paid for other substantially identical claims also submitted by Fremont to Defendants. In addition, based on numerous oral communications, which will be elicited through oral testimony at trial, an implied contract by and between Fremont and Defendants existed which provided that Defendants would pay Fremont for the non-participating claims, at a minimum, based upon the "usual and customary fees in that locality" or the reasonable value of Fremont's professional emergency medicine services. *See also* FESM000009-11 and FESM000335-341.

Request No. 21:

Please produce all communications Fremont has had with Defendants concerning the Healthcare Claims that Fremont is asserting in this Action.

Response to Request No. 21:

Fremont responds as follows: *See* Response to Request No. 17.

Request No. 22:

Please produce all written agreements with any third parties concerning the Healthcare Claims that Fremont is asserting in this Action.

Response to Request No. 22:

Objection. The request is overly broad in that it is not limited in scope, irrelevant and not proportional to the needs of the case considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit. In particular, the existence of any prior written agreement entered into with third parties which has no impact on Defendants' obligation to pay the appropriate rate for the Healthcare Claims makes such information unimportant to the issues at stake in this action. Furthermore, the burden and expense of gathering these agreements outweighs any benefit that would be derived from the same.

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Subject to and without waiving the foregoing objections, Fremont responds as follows: None.

Discovery is ongoing and Plaintiffs reserve their right to further supplement these responses.

DATED this 1st day of June, 2020.

McDONALD CARANO LLP

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 1st day of June, 2020, I caused a true and correct copy of the foregoing **PLAINTIFFS' FIRST SUPPLEMENT TO RESPONSES TO DEFENDANTS' FIRST SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS** to be served to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

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EXHIBIT 7

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EXHIBIT 7

UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF FLORIDA PENSACOLA DIVISION

SACRED HEART HEALTH SYSTEM, INC., et al.,

Plaintiffs,

v. **Case No. 3:07cv62/MCR/EMT**

[FILED UNDER SEAL][1]

HUMANA MILITARY HEALTHCARE SERVICES, INC.,

Defendant.
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ORDER

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The plaintiffs, Sacred Heart Health Systems, Inc. and a group of several other hospitals (collectively "the plaintiff hospitals")[2] each entered into network provider agreements with defendant, Humana Military Healthcare Services, Inc. ("Humana"), to provide civilian military healthcare, including certain outpatient laboratory and radiology services and equipment,[3] in exchange for reimbursement from Humana through the government program known as CHAMPUS/TRICARE.[4] In Count I of the Fourth Amended Complaint (doc. 345), the plaintiff hospitals allege that Humana breached the network provider agreements by changing the contract reimbursement rates for these services, and, in Count II, plaintiff Sacred Heart Health System, Inc. alleges fraudulent inducement in connection with the agreements. Humana filed counterclaims based on breach of

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[1] The order is sealed because it refers to and discusses several exhibits that have been filed under seal by the parties.

[2] All together there are 41 plaintiff hospitals.

[3] Reimbursement of the professional charges of physicians is not at issue.

[4] *See infra* Note 6.

contract and unjust enrichment, alleging that it is entitled to recoup overpayments from the plaintiff hospitals on claims exceeding the allowable charge or for claims based on billing errors (doc. 361).

Pending before the court is the Report and Recommendation ("R&R") of the magistrate judge filed on October 21, 2011 (doc. 541), regarding the parties' motions for partial summary judgment on two central issues that the court found to be common to all parties and suitable for potential early disposition.[5] The parties have been furnished a copy of the R&R and afforded an opportunity to file objections. The parties have filed timely objections (docs. 549, 552) and responses (docs. 570, 571), as well as motions to strike certain exhibits (*see* docs. 582, 590, 612, 627). Now, having fully considered the R&R, the parties' arguments and the record (including the transcript of the oral arguments), and being fully advised, the court concludes that the motions to strike are due to be granted in part and denied in part and the R&R adopted.

Background

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The court incorporates by reference the background of this case as stated by the magistrate judge in the R&R. However, because context will aid the court in its discussion of the issues below, the court provides a brief overview of the facts. The CHAMPUS/TRICARE program provides a system of healthcare to its beneficiaries, who are military family members and retirees, and is overseen by the TRICARE Management

[5] These two issues are: (1) whether the government mandated that Humana pay the hospitals lower rates, and (2) whether Humana will be permitted to litigate the underlying validity of individual benefit claims which allegedly have been paid in part. The parties filed partial motions for summary judgment on these issues (docs. 405, 407, 415) and the plaintiffs also filed a motion for summary judgment on Humana's counterclaims (doc. 449). In connection with these motions, the parties each filed statements of facts, memoranda of law, responses in opposition to the other party's motions as well as replies, and supporting materials. (See docs. 406, 408, 410, 411-14, 416, 417, 427, 428-31, 432, 433, 434, 435. 436, 437, 439, 440, 446, 447, 448, 450, 451, 452, 453, 454-62, 468, 469, 470, 481, 482 & 488). The court specially referred these motions to the Honorable Gary R. Jones, United States Magistrate Judge for the Northern District of Florida, for the preparation of a report and recommendation, pursuant to Fed. R. Civ. P. 72(b). *See* 28 U.S.C. § 636(b)(1)(B).

Activity ("TMA"), an agency of the Department of Defense ("DoD").[6] In 1995 and again in 2003, Humana contracted with the DoD to manage healthcare services provided to TRICARE and became the TRICARE Managed Care Support ("MCS") contractor responsible for establishing a network of medical care providers for "Regions 3 and 4" of the United States and the "South Region," including states of Alabama, Florida, Georgia, Mississippi, South Carolina, and a large portion of Tennessee. Pursuant to its MCS contracts, Humana entered into private contracts with the plaintiff hospitals located in these states, whereby the hospitals rendered health care services to TRICARE beneficiaries and obtained reimbursement in accordance with the terms of their network provider agreements. Humana reimbursed the network providers on the basis of the claim forms they submitted, which the plaintiff hospitals prepared from clinical records, using a series of coding rules that translated the medical information into a Health Care Common Procedural Coding System ("HCPCS") and other coding systems for processing. Humana paid claims based on the submitted forms. The government, in turn, paid Humana at fixed rates for healthcare costs, subject to periodic redetermination, using a risk-sharing formula whereby Humana and the government shared any increased costs or savings.[7]

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Under this reimbursement procedure, the clinical records were not submitted with the claim forms. Instead, pursuant to the TRICARE Operations Manual, the MCS contractor would review the face of the claim form to ensure the following: that the patient

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[6] CHAMPUS is the Civilian Health and Medical Program of the Uniformed Services, which was designed to supplement the government's system of direct medical care to military personnel by providing a program through which the government shares the cost of civilian medical care provided to beneficiaries (military dependents and retirees). *See* 10 U.S.C. § 1072(4) (defining CHAMPUS); *see also* 10 U.S.C. § 1071 (purpose). The DoD had used fiscal intermediaries to process CHAMPUS claims until the 1990s, when Congress began to implement its successor, the TRICARE program, through the TMA; TRICARE was designed to improve the quality, cost, and accessibility of medical services for beneficiaries. Under TRICARE, the DoD is authorized to enter Managed Care Support ("MCS") contracts with contractors, like Humana, to manage the TRICARE program for a given region. *See* 10 U.S.C. § 1072(7) (defining TRICARE); *see also* 10 U.S.C. § 1097 (authorizing the DoD to contract for the delivery of healthcare under TRICARE).

[7] Carl Akins, TMA Director, stated by declaration that the government paid Humana the required monthly health care price in accordance with the applicable MCS contract and Humana then was responsible for making timely and accurate payment to the network providers based on the terms of Humana's network provider contracts.

was eligible; that the provider was authorized under the TRICARE program; that the service was a benefit provided; that the service was medically necessary and appropriate under TRICARE; that the beneficiary was legally obligated to pay for the service; and that the claim form contained sufficient information to determine the allowable amount. The manual contained procedures by which MCS contractors could review claims after payment to providers in order to verify that the claims were legitimate and that accurate payment was made. Pursuant to such a post-payment audit, the MCS contractor could recoup any overpayments discovered.

Prior to October 1, 1999, Humana paid each of the plaintiff hospitals for outpatient radiology or laboratory services at either a percentage of the charges billed or a flat rate, depending on the respective terms of each provider contract. After October 1, 1999, Humana reimbursed hospital providers of outpatient radiology and laboratory services on the basis of the CHAMPUS Maximum Allowable Charges rates ("CMAC rates" or "CMAC Fee Schedules") set by the government.[8] As a result, the hospitals received less money for these services than they had received previously under their network contracts. When they disputed the change, Humana informed them that it was mandated by government policy requiring reimbursement according to CMAC rates.

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As a result of this change in the reimbursement rate, a few of the hospitals brought suit for breach of the network provider agreements and for fraudulent inducement. In response, Humana raised numerous affirmative defenses and asserted by counterclaim that it was entitled to recoup overpayments paid to the hospital plainitffs (due either to billing coding errors or to claims not supported by clinical records) on a theory of breach of contract or unjust enrichment. The hospitals sought class certification. This court granted class certification, finding commonality on grounds that Humana allegedly had changed the reimbursement policy for outpatient laboratory and radiology services as of October 1, 1999, regardless of the terms of the specific network provider agreements in

[8] TMA's predecessor, OCHAMPUS, issued a policy on March 3, 1992, that led to the creation of CMAC rates in response to a congressional mandate to control the maximum allowable payment to physicians, similar to the Medicare program, which applied to reimbursement of physician services.

order to comply with TRICARE policy, which was allegedly incorporated into the network provider agreements. That decision was reversed by the Eleventh Circuit on grounds that substantial variation in material contractual terms outweighed the common question and that individualized extrinsic evidence would be necessary for a determination of Humana's affirmative defenses, especially in light of substantial variations among the bodies of several states' laws that will apply. *See Sacred Heart Health Sys., Inc. v. Humana Military Healthcare Servs., Inc.*, 601 F.3d 1159 (11th Cir. 2010). Following remand, additional plaintiffs joined.

The case is now before the court on two common preliminary issues, which have been framed by the parties in summary judgment motions: (1) whether a federal mandate existed, requiring Humana to change the rate of reimbursement under the contracts, and (2) whether Humana should be permitted to litigate the validity of the underlying claims for which reimbursement is sought. The plaintiffs also have filed a motion for summary judgment as to Humana's counterclaims.

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The court referred the motions to the magistrate judge for oral argument and a report and recommendation, which now has been submitted. The R&R recommends that the motions be granted in part and denied in part. Specifically, the magistrate judge recommends granting the plaintiffs' motion for partial summary judgment on the government mandate issue based on the record evidence supporting a finding that there was in fact no government mandate to change the reimbursement rate, as well as on Humana's recent concession of the issue.[9] The magistrate judge recommends denying

[9] The R&R notes that prior to October 1, 1999, the date Humana changed the reimbursement rate, Humana had requested permission from the TMA to change the reimbursement from billed charges to CMAC rates through a letter drafted by Humana's Chief Medical Officer, Dr. John E. Crum. In response, the TMA issued a letter, drafted by TMA Contract Officer Beverly Carey in December 1998, stating that TMA needed more information and that Humana should "continue to operate under current guidelines," which at that time, the magistrate judge noted, was payment of billed charges. The R&R documents further evidence supporting the conclusion that there was no government mandate through Humana's Value Engineering Change Proposal ("VECP") submissions to TMA in 1999 and 2000, proposing that the reimbursement methodology be changed to CMAC rates. The magistrate judge noted that in September 1999, TMA's contracting officer, Beverly Carey, responded to Humana's VECP by stating that TMA's initial review showed it did not have the legislative authority to make the changes suggested; not that TMA policy required use of CMAC rates. In March 2000, the TMA rejected Humana's proposal, confirming that there had been no government mandate. (See Doc. 412, Ex. 40, 42). The magistrate judge concluded that regardless of whether the TMA permitted

Humana's motion for partial summary judgment on the CHAMPUS allowable issue because this issue is not common to all plaintiffs and will vary depending on the language of the individual provider agreements. The magistrate judge recommends denying the plaintiffs' motion regarding Humana's right to litigate the validity of the underlying claims because Humana is legally entitled to pursue that recovery. Finally, the magistrate judge recommends granting in part and denying in part the plaintiffs' motion for summary judgment on Humana's counterclaims, reasoning that judgment in favor of the plaintiffs is not appropriate except to the extent Humana seeks to recover overpayment on matters covered by the contracts under a theory of unjust enrichment, for which a claim for unjust enrichment does not lie.

The parties object to various portions of the R&R, and the court has now fully considered their arguments.

Discussion

A. Motions to Strike

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The court turns first to Humana's motion to strike three exhibits that the plaintiff hospitals attached to their response in opposition to Humana's objections to the R&R. The court finds that the objection is well-taken, at least in part. The magistrate judge heard oral argument on the motions on July 22, 2011, and took the case under advisement at the close of the hearing, consistent with the court's local rule. *See* N.D. Fla. Loc. R. 56.1(B). The R&R was filed in October 2011, and the parties each filed objections. In response to Humana's objection, the plaintiff hospitals attached three new exhibits, consisting of two emails from TMA employees to certain hospital providers during August and September, 2011, and also a TMA formal review decision dated June 2, 2011.[10] Plaintiffs argue that they properly cited the exhibits not as factual evidence but to contradict the May 26, 2011,

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alternate network reimbursement methodologies, there is no evidence that the government directed or mandated that Humana change the payment rate to the CMAC rate effective October 1, 1999.

[10] The plaintiffs also submitted a TRICARE/CHAMPUS policy manual dated June 25, 1999, as an exhibit, but this document was already part of the summary judgment record and thus, it is not within the scope of Humana's motion to strike.

deposition testimony of TMA official, Barbara Gallegos[11] and to respond to Humana's allegation that no further discovery would contradict its arguments regarding TMA policy. The plaintiffs assert that the new exhibits are not needed for resolution of the motions and that the emails did not exist prior to the submission date for the summary judgment motions. Moreover, the plaintiffs assert that the TMA formal review decision is legal authority, not factual information, although they recognize that it does contradict Gallegos's testimony factually. Humana argues that the late-filed exhibits violate local procedural rules dictating the time for submitting record materials in support of summary judgment and "slander" a TMA official without giving the TMA an opportunity to respond.[12]

The emails were drafted and sent after the advisement date for summary judgment purposes but before the magistrate judge issued the R&R. The plaintiffs attached the new exhibits to their response without seeking leave to supplement the summary judgment record, either before or after the magistrate judge filed the R&R. Because the plaintiffs did not seek leave to supplement the summary judgment record and, to date, have not requested leave to do so, the court will grant the motion to strike the emails, plaintiffs' Exhibits 1 and 2 (docs. 571-1, 571-2), which are undeniably factual in nature.

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The court agrees with the plaintiffs, however, that the formal review decision, although not binding precedent, is more akin to legal authority. Moreover, Humana has also supplemented the record with an arbitrator's final decision and stipulation from a case that was cited in the R&R and concluded after the R&R was issued.[13] (Docs. 610). The plaintiff hospitals move to strike Humana's notice, asserting it contains lengthy improper legal argument, which Humana opposes. (Docs. 612, 627). Despite the length of

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[11] Gallegos had testified in May that the CHAMPUS allowable "set rates" were established as CMAC rates at least as far back as October 1, 1999.

[12] Humana alternatively requests that the court reopen the record to permit the United States to be heard regarding allegations made in those exhibits – the United States is not a party. Humana also asserts its own need of an opportunity to rebut the evidence. The court denies the request to reopen the record because, as discussed below, the court will grant the motion to strike the factual emails.

[13] *See Southeast Georgia Regional Medical Center, Inc. et al. v. Humana Military Healthcare Services, Inc.*, AAA Case No. 11 193 889 10.

Humana's notice, the court finds that it offers only a summary of the decision, not legal argument. Therefore, the court finds it is appropriate to deny Humana's objection to the formal review decision, plaintiffs' Exhibit 3 (doc. 571-3), and to deny the plaintiffs' objection to the arbitrator's decision and stipulation submitted by Humana (docs. 610-1, 610-2).

B. Objections to the Report and Recommendation

Turning to the parties' objections, the court reviews *de novo* those portions of the R&R to which objections have been made. *See* 28 U.S.C. § 636(b)(1). The standards for ruling on a summary judgment motion are properly set forth in the magistrate judge's R&R, incorporated herein by reference. *See also* Fed. R. Civ. P. 56(a). The court applies those familiar standards but will not repeat them here.

1. Humana's Objections

a. Plaintiff's Motion for Partial Summary Judgment on Government Mandate

Based on the existing record, which now includes statements from TMA officials, Humana has conceded, contrary to its earlier position in response to the hospitals' complaint about the reimbursement change, that there was no government mandate that displaced the terms of the network provider agreements and thus required a change in the payment policy on October 1, 1999. Humana objects to the recommended grant of summary judgment in favor of the plaintiff hospitals on this issue, arguing that the existence of a government mandate is not an issue raised in the case, maintaining that it never took the position that the government required it to reimburse in a manner that was inconsistent with the network provider agreements.[14] The court disagrees. Humana originally took the position, admitted in discovery responses in April 2008, that it was "mandated by the federal government to impose CMAC fee schedules on network hospital outpatient radiology and laboratory services rendered on or after October 1, 1999." (Doc. 541, at 12 & Doc. 411, ex. 21). Now, in response to the hospitals' motion for summary judgment on the federal mandate issue and with the benefit of the government's position on the record, Humana states that it has never contended that a government-imposed

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[14] Humana also objects on grounds that the R&R fails to resolve factual inferences in its favor. The court sees no facts to infer in Humana's favor on this issue.

mandate required the plaintiff hospitals to accept reimbursement for the disputed services *at rates inconsistent with the parties' network provider agreements*. Its change in position is evident from the record evidence, as is the actual lack of a government mandate, which it now must concede.[15] Whether the contract language of the network provider agreements, combined with or incorporating TMA policy, supports Humana's interpretation of the reimbursement rate is a separate inquiry.[16] The court will grant the plaintiff hospitals' motion for partial summary judgment on this issue.

b. Humana's Motion for Partial Summary Judgment

In a motion related to the government mandate issue but with a new twist, Humana argues that each of the network provider agreements incorporated in various ways the TMA "CHAMPUS allowable charge" for outpatient non-surgical services and that this operated as a contractual limit on reimbursement. Thus, Humana argues it is entitled to a partial summary judgment finding, as a historical matter, that TMA policy during the relevant time interpreted the "CHAMPUS allowable charge" as the lesser of CMAC rates, network discounts, or billed charges when those services had sufficient HCPCS coding on the claim forms. The plaintiff hospitals respond that the "allowable charge" under the network agreements was the hospital's billed charges, consistent with prior practice and the network provider agreements. The R&R recommends denying the motion, and Humana objects on numerous grounds.

First, Humana argues that TMA's policy during the relevant period consistently defined the CHAMPUS allowable as the lesser of CMAC rates, network discounts, or billed charges, as evidenced by the deposition of TMA representative Barbara J. Gallegos (doc.

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[15] This is the first time in this lawsuit when the record has contained evidence of the TMA's position on the issue; nothing in the record supports a contention that the TMA mandated Humana to change the reimbursement rate in a manner that would be inconsistent with the network provider agreements.

[16] Humana also argues that the R&R misinterpreted key evidence. The court will discuss these arguments in connection with Humana's "CHAMPUS allowable" motion because partial summary judgment was proper on the government mandate issue in light of Humana's concession.

417-1) and TMA policy manuals.[17] In support of its argument, Humana contends that the R&R misinterprets or ignores key evidence, such as the TMA's December 1, 1998 letter; Gallegos's testimony; and Humana's VECP submissions (*see supra* Note 9). On review of the record, the court disagrees. Humana argues that the magistrate judge misinterpreted Beverly Carey's December 1, 1998 letter as indicating that Humana should continue paying billed charges, despite Gallegos's deposition testimony that the letter authorized use of CMAC rates consistent with TMA policy. However, it is clear from the record that the letter was a response to an inquiry by Humana in 1998 about whether it could apply CMAC fee schedules to network provider hospitals for outpatient radiology and laboratory services. Carey's letter stated that the proposal was "not inconsistent" with TMA policy but that TMA had not yet identified a method for converting the revenue codes; that when a hospital bills using the codes, "payment should be based on allowable charges including CMACs;" and finally, that TMA needed more information, and Humana should continue to operate under "current guidelines." (Pl. Ex. 32). Although Gallegos recently opined in her deposition testimony that this indicated CMAC rates should be applied and that this advice by Carey was consistent with existing TMA policy when the letter was written, other portions of the letter support a broader interpretation. For example, she stated that "payment should based on allowable charges *including* CMACs." Thus, this letter does not plainly restrict payment to CMAC rates, as suggested by Humana.

Moreover, the record includes evidence contrary to Gallegos's recent explanation. In deposition testimony, Dr. Richard J. Mancini, Director of Humana, and Dr. Crum, Humana's Chief Medical Officer responsible for administering the TRICARE program for Humana, each stated that the government allowable leading up to October 1, 1999, was

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[17] The TRICARE policy manual issued on June 25, 1999, provided that radiology, laboratory, and other diagnostic services that had CMAC rates should be priced at the lesser of CMAC rates, network discounts, or billed charges and outpatient services should be reimbursed on the basis of billed charges unless there was sufficient HCPCS coding information for the claim. However, the manual also plainly provided in each instance that alternative network reimbursement methodologies were permitted when approved and included in the network agreement. (*See* doc. 417-4, at 58-68).

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in fact billed charges.[18] This is consistent with all parties' understanding prior to October 1, 1999, when Humana had consistently reimbursed for outpatient services based on billed charges, and thus the court rejects Humana's argument that the magistrate judge misinterpreted the phrase, "current guidelines," in Carey's letter. Additionally, subsequent to Gallegos's deposition, the TMA issued a formal review decision indicating that the rule requiring the reimbursement of hospital outpatient radiology and laboratory services at an established allowable charge rate, based on procedure codes, was made retroactive to August 1, 2003, which also supports the magistrate judge's interpretation.[19] (Doc. 571-3).

Humana's VECP submissions also contradict Gallegos's assertion that CMAC rates had applied since 1999 or earlier. Humana, however, argues that the R&R misinterprets its VECP submissions. According to Humana, the VECP submissions were merely inquiries seeking permission to share its cost-saving ideas with other contractors across the nation, not seeking authorization to reimburse based on CMAC rates, which Humana asserts was already permitted under TMA policy. The court disagrees. One VECP cited Carey's letter for this authority. However, while that letter indicated that payment according to CMAC rates would not be inconsistent with TMA policy, Carey stated only that allowable charges included CMAC rates, and she did not venture an opinion on the meaning of

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[18] Each witness attempted to explain portions of this testimony further in errata sheets. In particular, Dr. Crum, testified by deposition that Humana paid billed charges, or a percentage of billed charges, for outpatient radiology and laboratory services during 1996, 1997, and 1998, and that he determined at some point that there was an "alternate method" they could use for paying that seemed consistent with TRICARE; thus, Humana changed the way it paid for those contracts as of October 1, 1999. Crum stated that the change was implemented "after we received direction from our contracting officer, Beverly Carey, that this was how they should be paid;" but he and his team played a role in initiating the change, and Crum conceived of the idea. (Crum depo. at 40-41). He testified that he did not give consideration to the language of the contracts in making this recommendation (he relied on others to consider the contracts). Later in the deposition he stated that he believed TRICARE limitations on reimbursement trumped the terms of the contract because Humana could not pay above the CHAMPUS allowable. (Crum depo. at 50-53). However, he also admitted that a letter dated May 1999 instructed them to "pay billed charges," and Crum explained that the issue was "in flux and unclear at this point." (Crum Depo. at 80-81). Crum explained in an errata page that by "flux" he meant that he did not know the status of the CMAC rate policy in other TRICARE program regions. Such explanations go to the weight of the testimony, and at this juncture, the court must view them in the light most favorable to the nonmoving party.

[19] The court has admitted this exhibit over Humana's objection.

allowable rates within any network provider agreement. Thus, regardless of what TMA policy actually permitted, it appears from the record that the VECPs were premised on an assumption that the existing payment methodology for outpatient radiology and laboratory services was based on the billed charges. Further, the VECP submissions indicate that reimbursement of billed charges was the going methodology: Humana suggested in its VECPs that TMA should change the wording of its policies to make it clear that CMAC rates applied to these services; Humana suggested that payment based on CMAC rates was an option that other MCS contractors were not aware of; and Humana discussed payment based on CMAC rates as a proposal that the government might yet reject. In fact, TMA rejected the VECP submissions.[20] If, as Gallegos testified, allowable charges meant CMAC rates under the clear practice and policy of TMA prior to 1999, Humana would not have needed to inquire in 1999 and 2000 about whether its proposal to apply the CMAC fee schedule to outpatient radiology and laboratory services was consistent with TMA policy. Additionally, Gallegos herself agreed in her deposition that the allowable charge for network contractor providers was the contracted amount. (Doc. 428-1, at 6). Thus, the record is not as clear as Humana suggests.

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Humana objects to the magistrate judge's conclusion that this claim is not ripe for determination and reiterates that it is not asking the court to delve into a contractual interpretation at this stage but rather to determine as an undisputed historical fact that under TMA policy, the "CHAMPUS allowable" was limited to CMAC rates. The court notes that in framing this issue for the court, Humana itself asserts that this alleged TMA policy was incorporated into the network provider agreements "in various ways." (Doc. 416, at 4). Thus, the TMA policy is only relevant if, and to the extent, it was incorporated into the agreements, and the issue therefore is dependent on a contract-by-contract review. For

[20] In one such rejection letter dated May 15, 2002, Humana was told that a new reimbursement approach was being developed regarding TRICARE's payments for hospital outpatient services and reminded that the MCS contractor's ability to negotiate discounts from network providers for hospital outpatient services; Humana was encouraged to "vigorously pursue cost reductions from their network providers." (Pl. Ex. 45).

this reason alone, summary judgment is not appropriate on this issue. Moreover, as noted by the magistrate judge, the record reflects that TMA's policy has evolved in piecemeal fashion over the years. Thus, TMA's current official policy that the allowable charge for outpatient non-surgical services is the lesser of CMAC rates, network discounts, or billed charges when those services have sufficient HCPCS coding on the claim forms is not entitled to controlling weight when interpreting the "allowable charge" language at issue in Humana's network provider contracts from October 1, 1999 through April 30, 2009.[21] Each contract will need to be considered on its own terms in light of the understanding of the parties and relevant TMA policies at the time of contracting.

Humana argues that the R&R's regulatory analysis is flawed. The court agrees with the magistrate judge, however, that the applicable regulations do not support the interpretation offered by Humana that the CHAMPUS allowable was at all relevant times the lesser of CMAC, network discounts or billed charges. Humana points out that the magistrate judge relied on a subsequent version of 10 U.S.C. § 1079(j) to conclude that every reimbursement methodology must be codified in the Code of Federal Regulations ("CFR"), arguing that the pre-2001 version of the statute was permissive in nature because it stated that reimbursement methodologies "may" be determined under the regulations, not "shall." In the court's view, this is not a material distinction because the regulation listed "billed charges and set rates" as permissible reimbursement methods. Humana argues that the phrase "set rates" in 32 C.F.R. § 199.14(a)(3) meant CMAC rates, but this interpretation is not supported by the regulation's text, which did not limit reimbursement

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[21] Humana argues that the agency deference analysis in the R&R is legally and factually flawed because the validity of the agency policy itself is not at issue; instead, TMA's policy as a factual and historical matter is at issue. The court agrees with this statement of the issue, but the R&R is not at odds with this view and does not comment on the validity of the policy. The magistrate judge reasons only that the TMA's current "allowable charge" interpretation is not entitled to controlling weight because it is not consistent with its earlier pronouncements, finding no reason to apply either *Chevron* or *Skidmore* deference. *See Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837 (1984); *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944). Also, the magistrate judge notes that Gallegos's deposition testimony is not entitled to controlling weight because it is contrary to other evidence and appears to be merely a litigation position, citing *U.S. Steel Mining Co. v. Director, OWCP*, 386 F.3d 977, 986 (11th Cir. 2004). The court agrees with this reasoning.

in this manner.[22] The regulation did not reference CMAC rates for outpatient services until 2002, when CMAC rates were referenced solely with regard to outpatient radiology services. *See* 32 C.F.R. § 199.14(a)(1998) through (2002). Notably, by contrast, CMAC rates were specifically referenced in the context of physician reimbursement methods in 1998. *See* 32 C.F.R. § 199.14(h) (1998). Also, as the magistrate judge noted, the regulations specific to TRICARE contemplated deviations from the CHAMPUS reimbursement system, citing 32 C.F.R. § 199.17, *et seq.* The court is not drawing a conclusion that "set rates" could *not* be CMAC rates – only that the language of the regulation was not limited to CMAC rates as Humana suggests, and thus, the magistrate judge did not commit legal error.

This view is consistent with prior cases. As noted in the R&R, the Sixth Circuit, construing a network provider agreement in light of the regulations that are at issue in this case, concluded that "the federal regulations and associated TRICARE policies incorporated into the parties' agreement by reference [did] not categorically bar an independent managed care support contractor, such as Humana, from paying sums in excess of government allowables on certain claims." *Baptist Phys. Hosp. Org. v. Humana Military Healthcare Servs., Inc.*, 368 F.3d 894, 900-01 (6th Cir. 2004) (citing *Bay Med. Ctr.*, Case No. 5:30cv144 (N.D. Fla. Mar. 16, 2004)). The court noted that Humana's contract with the DoD provided that claims were subject to the maximum payment methodology set forth in federal law but that the contractor could pay additional sums if "necessary to entice providers into the network" and explained that under the TMA's policy, MCS contractors were "free to establish alternative reimbursement systems that will ensure adequate beneficiary access to quality network providers." *Id.* at 900. Consistently, in this case, Gallegos confirmed by deposition that Humana's contract included the language that the contractor may pay network providers additional sums if deemed necessary to entice

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[22] Furthermore, as the plaintiff argues, there is an indication in the TRICARE/CHAMPUS policy manual dated June 25, 1999, that "set rates" could mean rates set by providers in certain instances (doc. 571-4, at 1).

providers into the network. Also, a 1999 policy manual indicates that alternate network reimbursement methodologies were permitted "when approved by TMA and specifically included in the network provider agreement" (doc. 171-4, at 1).

Finally, the court rejects Humana's argument that the R&R ignores regulatory and evidentiary support for applying CMAC rates. The court acknowledges that the record contains conflicting evidence on this issue, some of which, namely Gallegos's testimony and TMA policy manuals, does provide support for Humana's position.[23] The conflicting evidence only confirms that questions of fact exist.

Humana suggests for the first time that its motion should be granted at least in *part* based on the DoD's express inclusion of CMAC rates with regard to laboratory and radiology outpatient services in its Interim Final Rule on June 13, 2002. The court disagrees. The rule stated that it would become effective 60 days from the date it was published or as soon thereafter as TMA could effectively and efficiently implement it through contract changes. This, too, confirms that material questions of fact remain regarding the contracts. Determining whether the TMA policy regarding the "CHAMPUS allowable" was necessarily incorporated into each network provider agreement and whether it limited the contractual reimbursement to the lesser of CMAC rates, network discounts, or billed charges when proper coding was used will need to proceed on a contract-by-contract basis, precluding entry of summary judgment in favor of Humana on this issue.

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[23] Additionally, for instance, a letter to a network hospital dated October 16, 2001, from Captain John D'Allisandro of TMA cites the March 10, 2000 Policy Manual for the conclusion that "TRICARE policy is that outpatient hospital services will be reimbursed on the basis of billed charges unless sufficient CPT coding is available in which case CMAC is applied." (Pl. Ex. 44). He first indicated that the question needing resolution was "whether it is inconsistent with or prohibited by the statutory scheme . . . to apply CMAC reimbursement to outpatient hospital services," and he noted, "[t]here is at present no established, separate reimbursement methodology for outpatient services other than hospital based ambulatory surgery centers." (Pl. Ex. 44). Nonetheless, he concluded, "we do not believe it necessarily follows that it is improper to apply CMAC reimbursement to outpatient hospital services when sufficient CPT code information is available." (Pl. Ex. 44). In an earlier letter from D'Allesandro, he stated it was policy is to reimburse on the basis of the lesser of billed charges or set rates while also recognizing that "there may be services rendered by a hospital that are outside the scope of set rates." (Pl. Ex. 43). Inconsistencies therefore exist even within the evidence that supports Humana's position.

2. Plaintiffs' Objections

a. Plaintiffs' Motion for Partial Summary Judgment on Whether Humana can Litigate the Underlying Validity of Individual Benefit Claims

The plaintiff hospitals object to the R&R, asserting that Humana should not be permitted to challenge the underlying validity of the claims at issue. The court has reviewed the plaintiff's objections to this recommendation and finds them to be without merit for the reasons stated in the R&R: the plaintiff hospitals have the burden to establish an entitlement to payment; the plaintiff hospitals have placed at issue the payments they have already received; and Humana therefore has a legal right to go beyond the claim forms and recoup any claims erroneously paid. The R&R carefully cites cases from each relevant state for the proposition that a party may assert a compulsory counterclaim for recoupment for money damages even where the claim may be barred by the statute of limitations. (*See* Doc. 541, at 33 & cases cited therein).

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The plaintiffs' arguments are based on the faulty premise that the magistrate judge in fact determined that the CHAMPUS allowable was *not* the CMAC rates; a conclusion from which the plaintiffs then argue that Humana plainly breached the individual contracts by applying CMAC rates. The plaintiffs assert that, in light of Humana's clear first breach, Humana has no right to challenge the validity of the underlying claims and should not be permitted discovery on the individual claims. Although appealing from a simplistic standpoint, plaintiffs' analysis falls short; its assertion that Humana breached the contracts is premature. This court has found that there are questions of fact precluding summary judgment on the CHAMPUS allowable question and in so doing expressly recognizes that the phrase "set rates" could include CMAC rates based on disputes existing in this record. For the same reason, the court rejects the plaintiff hospitals' argument that Humana has lost its right to litigate the individual claims by its own anticipatory breach, partial nonperformance, laches, waiver, or estoppel. These equitable arguments all rest on facts that are in dispute.

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The court also rejects the plaintiffs' assertion that they can meet their burden of

proof in this type of generalized manner, that is, by showing simply that Humana ceased to pay the billed rates as of October 1, 1999, regardless of the terms of the provider agreements. The plaintiffs rely on *Klay v. Humana, Inc.*, 382 F.3d 1241 (11th Cir. 2004) (addressing the issue of class certification regarding contract claims), for this proposition. The court finds *Klay* to be distinguishable. There, the court opined that the plaintiffs might be able to prove breach of contract with generalized proof in a situation where the breach could be attributed to the error of a billing program that automatically grouped together on a form two procedures that should have been billed separately, resulting in reimbursement of only one. *See id.* at 1264-65. That is not comparable to the facts at issue in this case, where the alleged breach was caused by a change in reimbursement rates and there is no undisputed evidence in the record regarding whether or when the CMAC rates took effect that applies across-the-board to all contracts.[24]

The plaintiffs assert that Humana is on a mere fishing expedition to uncover a potential defense and deny that they have placed the validity of the claims at issue. The court disagrees. Discovery is not yet complete. Humana's assertion that errors in individual claims may exist is sufficient to state a plausible claim in these circumstances. Although the network hospitals submitted claims for reimbursement of services provided on forms using HCPCS codes to identify the services provided, clinical records were not submitted with the claim forms. A claim is considered a "clean claim" if it contains the required coding and basic information from which it can be determined that the service is covered and the beneficiary is eligible; but this does not certify that the claim form was accurately coded, that it accurately described the services or the medical need for them, or that the services were actually performed. The plaintiff hospitals have exclusive control over the primary-source clinical records that are needed to determine whether claims were improperly supported or properly coded. According to the record, such errors are not

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[24] *See also Sacred Heart Health Sys., Inc. v. Humana Military Healthcare Servs., Inc.*, 601 F.3d 1159, 1176 (11th Cir. 2010) (denying class certification in this case after finding that there are "many individualized payment clauses contained in the network agreements").

uncommon.[25] Humana has both a right and an obligation under TMA regulations to recoup overpayments. *See* 32 C.F.R. § 199.11(f)(1) (indicating erroneous payments are not authorized by law and that due to the nature of the network provider agreements, recoupment procedures may be modified or adapted to conform to network agreements). Furthermore, the plaintiffs admitted during oral argument that "there is no end point" to the claims review procedure (doc. 508, at 154). The court concludes that Humana may challenge the validity of the individual claims. The plaintiffs alternatively request that the court stay discovery on the underlying claims until summary judgment motions on each provider contract have been determined. Given the protracted nature of this litigation and the anticipated further scope of the litigation, the court declines to add another layer of delay.

b. Plaintiffs' Motion for Summary Judgment With Respect to Humana's Counterclaims

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The magistrate judge recommends granting this motion as to unjust enrichment counterclaims where the right to reimbursement is covered by the contract provisions, but denying the motion as to Humana's contract counterclaim and those unjust enrichment counterclaims where reimbursement is not governed by express provisions of the contract. The plaintiffs object to the recommended partial denial of their motion. They reassert their arguments that Humana's breach of contract counterclaim was deficient as a matter of law. The undersigned agrees with the reasoning of the magistrate judge that the plaintiff hospitals are not entitled to summary judgment on Humana's breach of contract

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[25] Humana asserts that 39 of the 41 plaintiffs in this lawsuit have admitted that at least one of their payors sought a refund during the relevant period on grounds that the hospital submitted a claim using incorrect HCPCS coding, and that all but one have admitted that payors have sought a refund on grounds that the underlying clinical records did not evidence the services described in the claim forms. Moreover, every hospital has admitted that an audit during the relevant period discovered instances in which clinical records did not document a billed service. Humana notes that 27 of the 41 plaintiffs in this suit were listed as "settling hospitals" in a $900 million False Claims Act settlement between Tenet Healthcare Corporation ("Tenet") and the United States of America, and included in the United States' allegations were that these 27 Tenet hospitals had submitted outpatient claims to the CHAMPUS/TRICARE program for services not provided to patients. (*See* doc. 433, at 45-46; doc. 570, at 15-16). Viewing the record in the light most favorable to the nonmoving party, Humana, the court concludes that errors are not uncommon and Humana should be permitted to pursue them at this stage of the proceedings.

counterclaim at this time and incorporates that analysis without further comment. The plaintiffs also raise the new argument that, in light of the R&R's recommendation on the mandate and CHAMPUS allowable issues, Humana should not be permitted to proceed with expensive discovery on a breach of contract counterclaim "that soon will be precluded because of Humana's anticipatory breach and subsequent partial performance breaches." (Doc. 549, at 28). This argument assumes too much for this stage of the proceedings and has in essence already been addressed and rejected above; again, court agrees with the analysis in the R&R. The plaintiffs' suggestion that the court stay discovery is denied.

The plaintiff hospitals also argue that they are entitled to summary judgment on all of Humana's unjust enrichment claims, arguing that Humana is precluded from pleading alternatively because the subject matter of the counterclaim is covered by the contracts, and they assert it is undisputed that every claim at issue was covered by a network contract. According to Humana, however, the existence of valid contracts during the relevant time of the claims is not so clear for every provider.[26] Humana references a dispute of fact regarding whether 13 hospitals revoked their offer to enter the written contract before Humana accepted it, leaving the parties to have operated under a contract implied in fact. This alleged dispute of fact is the subject of a separate and still-pending motion for summary judgment, so for purposes of the current motion, the court will assume the question of fact is in dispute – viewing the record in the light most favorable to Humana and reserving this issue for determination in connection with the subsequent still-pending motion. Also, Humana argues that there is a dispute regarding the plaintiff Tenet South Fulton, Inc., which brought suit under an interim agreement with an effective date no later than February 24, 1997, which was effective for one year (doc. 345-17), although its claims in this suit are for services rendered beginning February 2001 through January 2009 (*see*

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[26] The R&R rejects, as unsupported by the record, Humana's assertion that because some plaintiffs left the network, no contract covered their claims. The R&R states that the only plaintiff Humana referenced with regard to this argument was The Medical Center, and the record reflects that The Medical Center is not suing for any claims reimbursed beyond the date its contract ended in December 2001. The court finds this is correct as to The Medical Center (*see* doc. 459-3, at 14 (stating The Medical Center claims improper reimbursement from October 1, 1999, through December 1, 2001)).

doc. 461-3, at 13). Humana argues that even assuming it had some agreement at some point with each of the plaintiffs, its alternative unjust enrichment claim should be allowed to stand in the event it is determined that a contract does not cover the plaintiffs' billing and coding errors in any particular instance. The court agrees. Notwithstanding, however, the court also agrees with the plaintiffs that if a contract governs the subject matter, Humana's counterclaim for reimbursement due to billing errors or the plaintiff hospitals' failure to provide the requisite primary source documentation would be limited to a breach of contract claim, and thus there could be no unjust enrichment claim. *See Rushing v. Wells Fargo Bank, N.A.*, 752 F. Supp. 2d 1254, 1265 (M.D. Fla. 2010). With that said, because Humana has raised some questions concerning the validity or duration of some contracts, it would be premature to dismiss the unjust enrichment claim at this time. *See Williams v. Bear Stearns & Co.*, 725 So. 2d (Fla. 5th DCA 1998) (noting that until an express contract is proven, a motion to dismiss a claim for unjust enrichment is premature); *see also Mobil Oil Corp. v. Dade Cnty Esoil Mgm't Co.*, 982 F. Supp. 873, 880 (S.D. Fla. 1997) ("[I]t is only upon a showing that an express contract exists that the unjust enrichment . . . count fails. Until an express contract is proven, a motion to dismiss a claim for . . . unjust enrichment on these grounds is premature.").

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Accordingly:

1. The magistrate judge's Report and Recommendation (doc. 541) is hereby adopted and incorporated by reference in this order.

2. The Plaintiffs' Motion for Partial Summary Judgment on Issue Related to Alleged Federal Government Mandate (doc. 405) is **GRANTED**.

3. The Defendant's Motion for Partial Summary Judgment (doc. 415) is **DENIED**.

4. The Plaintiffs' Motion for Partial Summary Judgment on Issue Related to Wether Humana Can Litigate the Underlying Validity of Individual Benefit Claims (doc. 407) is **DENIED**.

5. The Plaintiffs' Motion for Summary Judgment with Respect to Defendant's

Counterclaim (doc. 449) is **GRANTED in part** and **DENIED in part**.

6. The Defendant's Motion to Strike (doc. 582) is **GRANTED** in part as to Exhibits 1 and 2 (doc. 571-1, 571-2) and **DENIED** in part as to Exhibit 3 (doc. 571-3).

7. The Plaintiffs' Motion to Strike (doc. 612) is **DENIED**.

DONE AND ORDERED this 30th day of March, 2012.

M. Casey Rodgers

M. CASEY RODGERS
CHIEF UNITED STATES DISTRICT JUDGE

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
PENSACOLA DIVISION

SACRED HEART HEALTH
SYSTEM, INC., et al.,

Plaintiffs,

v. Case No. 3:07-cv-62-MCR-EMT

HUMANA MILITARY HEALTHCARE
SERVICES, INC., a Delaware corporation,

Defendant.
_____/

REPORT AND RECOMMENDATION

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Pending before the Court on Orders of Reference[1] are: (1) Plaintiffs' Motion For Partial Summary Judgment On Issue Related to Alleged Federal Government Mandate (Doc. 405)[2]; (2) Plaintiffs' Motion for Partial Summary Judgment On Issue Related To Whether Humana Can Litigate The Underlying Validity of Individual Benefit Claims (Doc. 407)[3]; (3) Humana Military Healthcare Services, Inc.'s Motion For Partial Summary Judgment (Doc. 415)[4]; and (4) Plaintiffs' Motion And Memorandum For

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[1] Docs. 442 & 463.

[2] In support of the motion Plaintiffs also filed a Statement of Facts. Doc. 406. In response Defendant filed a Response to Plaintiffs' Statement of Facts In Support of Plaintiffs' Motion For Partial Summary Judgment on Alleged Federal Government Mandate. Doc. 436.

[3] In support of the motion Plaintiffs filed a Statement of Facts. Doc. 408. In response Defendant filed a Statement of Genuine Disputes That Preclude Entry of Partial Summary Judgment in Plaintiffs' Favor On Claim Validity. Doc. 433. Plaintiffs filed a Response to Defendant's Statement of Genuine Disputes. Doc. 452.

[4] Defendant also filed a Memorandum of Law in support of the motion, Doc. 416, and a Statement of Facts as to Which There Is No Genuine Issue To Be Tried In Support of Defendant Humana Military Healthcare Services, Inc.'s Motion For Partial Summary Judgment. Doc. 417. Plaintiffs filed a Response to Humana's Statement of Facts. Doc. 435.

Summary Judgment With Respect to Humana's Counterclaim. (Doc. 449.)[5] The parties have filed opposition memoranda,[6] reply memoranda[7] and supporting materials.[8] On July 22, 2011, the undersigned heard oral argument on the motions and thus the motions are ripe for review

For the reasons discussed below, it is respectfully recommended that: (1) Plaintiffs' Motion For Partial Summary Judgment On Issue Related to Alleged Federal Government Mandate (Doc. 405) be granted; (2) Humana Military Healthcare Services, Inc.'s Motion For Partial Summary Judgment (Doc. 415) be denied; (3) Plaintiffs' Motion for Partial Summary Judgment On Issue Related To Whether Humana Can Litigate The Underlying Validity of Individual Benefit Claims (Doc. 407) be denied; and (4) Plaintiffs' Motion For Summary Judgment With Respect to Humana's Counterclaim (Doc. 449) be granted in part and be denied in part.

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I. BACKGROUND

In Count I of the Fourth Amended Complaint, Plaintiffs – each of whom is a hospital who contracted in writing with the Defendant, Humana Military Healthcare Services, Inc. ("Humana") – allege that Humana breached their respective network provider agreements by underpaying each of them for outpatient laboratory and

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[5] In support of the motion Plaintiffs filed a Statement of Facts. Doc. 453. In response Defendant filed a Statement of Genuine Disputes That Preclude Entry of Summary Judgment. Doc. 469.

[6] Docs. 427, 432, 434 & 468.

[7] Docs. 446, 448, 450 & 482.

[8] Docs. 411-14, 428-31, 437, 439, 440, 447, 451, 454-462, 470, 481 & 488.

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radiology services[9] rendered to beneficiaries of the CHAMPUS/TRICARE program. In Count II of the Fourth Amendment Complaint, Plaintiff Sacred Heart Health Systems, Inc., brings a claim against Humana for fraudulent inducement.

Because the issues before the Court on the respective motions for summary judgment concern the CHAMPUS/TRICARE program a brief review of the background of the program and the relationship between Plaintiffs and Humana is necessary.

The program initially was enacted by Congress to provide healthcare for military dependents and retirees and was to be provided solely in facilities run directly by the uniformed services. Later, Congress instituted CHAMPUS[10] as a supplement to this direct care medical system. Under this program and prior to the implementation of TRICARE, the Department of Defense ("DoD") used claims processors, referred to as fiscal intermediaries, to process claims under the CHAMPUS program. In the 1990's, however, the program changed when Congress established the TRICARE program,[11] which offered three coverage options: (1) a health maintenance organization, (2) a preferred provider organization, and (3) a fee-for-service benefit. One of the "principal mechanisms for the implementation of TRICARE" was "the procurement of Managed

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[9] The services which are the focus of the dispute in this case involve only the fees charged by institutional providers for use of radiological and laboratory equipment and do not involve the professional charges of the physicians who were involved with the delivery of the hospitals' radiological or laboratory services.

[10] "CHAMPUS" is the acronym for the Civilian Health and Medical Program of the Uniformed Services.

[11] Schism v. United States, 316 F.3d 1259, 1268 (Fed. Cir. 2002), *cert denied* 123 S.Ct. 2246 (2003).

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Care Support contracts for the provision of civilian health care services ... "[12] Thus, when TRICARE was implemented the DoD began to use Managed Care Support ("MCS") contractors, like Humana, to manage the TRICARE program in a given region.

On January 23, 1996, Humana and the DoD entered into a MCS contract for the regions which included Alabama, Florida, Georgia, Mississippi, South Carolina and a large portion of Tennessee.[13] Pursuant to its MSC contract Humana was required to deliver health care services to the beneficiaries by establishing a network of institutional providers, such as hospitals, and individual providers, such as physicians, by entering into private contracts with those network providers. Each of the Plaintiff hospitals in this case entered into managed care provider contracts with Humana.[14] The various provider contracts between the Plaintiff-hospitals and Humana, form the basis of Plaintiffs' claims for breach of contract in Count I of the Fourth Amended Complaint. Under each of the provider agreements the Plaintiff/hospital would render services to TRICARE beneficiaries and Humana would reimburse the Plaintiff/hospital in accordance with the terms of the provider agreement. The government would then pay Humana at fixed rates for healthcare costs, subject to periodic redetermination using a risk-sharing formula by which Humana and the government would share increased costs or savings.

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[12] 60 Fed. Reg. 52,078 (October 5, 1995).

[13] The 1995 MSC contract awarded Humana the MCS contract for regions 3 and 4. In 2003 Humana was awarded the MSC contract for the South Region, an area which included regions 3 and 4 as well as certain additional states.

[14] *See,* Exhibits 1-31 attached to the Fourth Amended Complaint. (Doc. 345.)

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Prior to October 1, 1999, Humana paid each Plaintiff/hospital for hospital outpatient radiology and laboratory services either at a percentage of the charges the hospital billed or at a flat rate. On November 18, 1999 payment under the provider agreements changed for outpatient laboratory and radiology services incurred after October 1, 1999. Effective October 1, 1999 Humana paid hospital providers for outpatient laboratory and radiology services on the basis of CHAMPUS Maximum Allowable Charges, also referred to as CMAC rates. Payment to the hospitals at the CMAC rates resulted in the hospitals receiving lower payments than under the billed charges/flat fee structure. This change in the payment rates is the core of the dispute in this case.

II. SUMMARY JUDGMENT STANDARD

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Pursuant to Federal Rule of Civil Procedure 56(c), the entry of summary judgment is appropriate only when the Court is satisfied that "there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." In applying this standard, the Court must examine the pleadings, depositions, answers to interrogatories, and admissions on file, together with any affidavits and other evidence in the record "in the light most favorable to the nonmoving party. Samples on Behalf of Samples v. Atlanta, 846 F.2d 1328, 1330 (11th Cir. 1988). As the Supreme Court held in Celotex Corp. v. Catrett, 477 U.S. 317 (1986), the moving party bears the initial burden of establishing the nonexistence of a triable issue of fact. If the movant is successful on this score, the burden of production shifts to the non-moving party who must then come forward with "sufficient evidence of every element that he or she must prove." Rollins v. Techsouth, 833 F.2d 1525, 1528 (11th Cir. 1987). The non-

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moving party may not simply rest on the pleadings, but must use affidavits, depositions, answers to interrogatories, or other admissible evidence to demonstrate that a material fact issue remains to be tried.

Although the parties only seek partial summary judgment in the motions pending before the Court, a request for summary judgment on "part of [a] claim or defense is authorized under Rule 56(a).[15] The motion of course must address an issue that is relevant to a claim or defense.

III. DISCUSSION

A. Introduction

The Court invited the parties to file early dispositive motions relating to two central issues common to all parties. As explained by the Court these issues are: (1) Whether the federal government mandated that Humana pay the hospitals lower rates, and if so, what legal impact, if any, that had on Humana's contracted obligation to plaintiffs; and (2) whether Humana can litigate the underlying validity of individual benefit claims which allegedly have been paid in part.[16] In response to the Court's invitation the parties have filed several motions for partial summary judgment – some of which are related to each other.

Plaintiffs' Motion For Partial Summary Judgment On Issue Related to Alleged Federal Government Mandate (Doc. 405)(the "Federal Mandate Motion") is related to Humana Military Healthcare Services, Inc.'s Motion For Partial Summary Judgment

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[15] *See,* Rule 56 advisory committee's note; 11 *Moore's Federal Practice* § 56.02[4](d ed. 2011)(2010 amendments to Rule 56 "make clear that" it is proper to seek summary judgment "on an issue that would not, if granted, lead to the resolution of a claim or defense.")

[16] Doc. 376, (Order on Discovery and Trial Plan), p. 2, ¶4, and p. 3 ¶5(G).

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(Doc. 415)("Humana's Summary Judgment Motion".) In Plaintiffs' Federal Mandate Motion Plaintiffs request the Court to enter partial summary judgment "declaring and ordering that the federal government did not mandate that Humana limit payment to the hospital plaintiffs to the lower CMAC fee schedules for hospital outpatient non-surgical services rendered beginning October 1, 1999." In Humana's Summary Judgment Motion, Humana requests that the Court enter partial summary judgment "that, from October 1, 1999, through April 30, 2009, the CHAMPUS/TRICARE allowable charge for the disputed services at issue ... was the lesser of CMAC rates, network discounts, or billed charges."

These two motions are related in the sense that both motions address the issue of the justification supporting Humana's decision to change the payment policy for outpatient laboratory and radiology services effective October 1, 1999. Anticipating that Humana intends to defend on the basis that Humana was mandated by the federal government to change its payment policy, Plaintiffs contend that Humana was not required or mandated by the TRICARE Management Activity ("TMA")[17] to pay its network providers using the CMAC schedules. Rather than challenging Plaintiffs on this issue Humana recasts the issue. Humana concedes it was not mandated by TMA to change its payment policy to amounts inconsistent with the terms of the network provider agreements. Instead, Humana asserts that the lower CMAC charge provided for by TMA operated as a contractual limit on the reimbursement to each hospital for the disputed services.

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[17] TMA is a unit of the Defense Department that administers TRICARE for the government.

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Plaintiffs also have filed a Motion For Partial Summary Judgment On Issue Related to Whether Humana Can Litigate the Underlying Validity of Individual Benefit Claims (Doc. 407)(the "Right to Litigate Individual Claims Motion"). In this motion Plaintiffs request the Court to enter partial summary judgment in their favor "finding that Humana cannot litigate the underlying validity of individual benefit claims which it has paid, in part, as 'clean claims;' and denying any discovery sought by Humana involving the validity of those individual benefit claims."

Lastly, Plaintiffs have filed a Motion for Summary Judgment With Respect to Humana's Counterclaim. (Doc. 449.) Humana's Counterclaim purports to allege claims for breach of contract in Count I and claims for unjust enrichment in Count II. In the breach of contract counterclaim Humana seeks recovery of any payments made to and accepted by the Plaintiff hospitals in excess of the CMAC charges. Additionally, Humana requests recovery of monies paid to and accepted by the Plaintiff hospitals, which were in error. Humana's breach of contract counterclaim in this sense is related to the argument in Humana's Summary Judgment Motion that CMAC was the allowable limit for payments to the network providers for outpatient laboratory and radiology services. Additionally, Humana's breach of contract counterclaim is related to Plaintiffs' Right to Litigate Individual Claims Motion in the sense that Humana's right to examine and contest individual claims, which have been paid already, is a condition precedent to Humana's right to recoup from Plaintiffs any payments in excess of CMAC.

While the Court recognizes that the primary purpose of filing these early dispositive motions was to narrow the issues and focus this large and complex case the Court is, nonetheless, required to rule on the issues presented in the motions in the

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context of the burdens placed upon the parties under Rule 56 of the Federal Rules of Civil Procedure. Thus, for example, while Humana requests the Court to enter partial summary judgment regarding the meaning of CHAMPUS Allowable, the Court has not been requested to rule upon the specific payment provisions of any particular provider agreement.

Although the motions for partial summary judgment present interrelated issues, because the Court is required to view the evidence in the light most favorable to the nonmoving party and because the moving party bears the initial burden of establishing the nonexistence of a triable issue of fact, the Court will address each of the motions for partial summary judgment separately.

B. Plaintiffs' Federal Mandate Motion

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With respect to the Federal Mandate Motion Plaintiffs and Humana frame the issue very differently.

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Relying upon Humana's responses to Plaintiffs' request for admissions, Plaintiffs contend that Humana has raised a disputed issue as to whether Humana was *mandated* by the federal government to impose CMAC fee schedules on network hospital outpatient radiology and laboratory services rendered on or after October 1, 1999. Plaintiffs then offer a convincing argument that there was no federal mandate which trumped the provisions of the network agreements and required Humana to change the fee schedules effective October 1, 1999 to the lower CMAC rates.

In its opposition memorandum, Humana concedes the point and does not challenge Plaintiffs argument that there was no federal mandate, which required Humana to change the payment policy on October 1, 1999. Instead, Humana frames

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the issue as whether the allowable charge operated as a contractual limit on the reimbursement to each hospital for the disputed services. Humana then reasons that because the question presented in Plaintiffs' motion is not material to the resolution of the breach of contract claim – and there is no dispute regarding the federal mandate – the Court should deny Plaintiffs' Federal Mandate Motion. Humana goes on to argue that in addition to requesting the Court to resolve a defense that Humana does not assert, Plaintiffs' motion should be denied on the ground that the evidence proffered by Plaintiffs does not support Plaintiffs' interpretation of TRICARE policy.

Humana's argument that CMAC operated as a contractual limit on the reimbursement of each hospital is an issue presented in Humana's Summary Judgment Motion and is not an issue which the Court needs to address in resolving the Federal Mandate Motion. The Federal Mandate Motion narrowly presents the issue of whether because of Humana's concession on the issue the Court should simply deny the motion for partial summary judgment as not relevant to a claim in the case. As explained below, however, while Humana's concession on this issue makes resolution of the motion easy, summary judgment in favor of Plaintiffs on this issue is still due to be granted because Humana has taken the position in this case that the change in the reimbursement rate was imposed upon Humana by the government.

Humana reasons that resolution of the federal mandate issue is not material to Plaintiffs' breach of contract claim and therefore under Rule 56 entry of an order granting partial summary judgment is not appropriate or necessary. Humana says because its defense does not rest upon the presence of a federal mandate the motion for summary judgment must be denied. As support, Humana points to the position it

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took when briefing class certification before this court and before the Eleventh Circuit Court of Appeals. In opposing class certification before this Court Humana argued that "Humana does not contend that Government policy "trumped" the terms of the network provider agreements."[18] And on appeal Humana told the Eleventh Circuit "[t]he core of the dispute [is] not whether the government mandated that Humana pay CMAC rates, but whether each hospital agreed to accept CMAC rates."[19] While these representations certainly suggest that the focus of Humana's defense in this case was not the federal mandate the Eleventh Circuit apparently did not view the issue as abandoned. In discussing Humana's justification for the change in the payment policy in this case the Eleventh Circuit in its decision reversing this Court's order granting class certification characterized Humana's position as: "Humana justified the change on the ground that the TRICARE Management Activity ("TMA"), a unit of the Defense Department that administers TRIACARE for the government, had *imposed* CMAC as the new "CHAMPUS allowable."[20] (emphasis added).

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In stark contrast to Humana's position opposing class certification, Humana served responses to Plaintiffs' requests for admissions, which in the Court's view, leave little question that Humana took the position in this case that the change in the payment policy effective October 1, 1999 was due – at least in part – to a federal directive or mandate. Humana was asked to admit or deny the following:

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[18] Doc. 221, at 3.

[19] Def's App. Br. At 17, Sacred Heart Health Sys., Inc. v Humana Military Servs., Inc., 601 F.3d 1159 (11th Cir. 2010(No. 08-16430).

[20] 601 F.3d at 1166.

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1. Admit that Humana Military Health Services, Inc. was mandated by the federal government to impose CMAC fee schedules on network hospital outpatient radiology and laboratory services for services rendered on and after October 1, 1999. Response: Admitted.

2. Admit that Humana Military Health Services, Inc. was not mandated by the federal government to impose CMAC fee schedules on network hospital outpatient radiology and laboratory services for services rendered on an after October 1, 1999. Response: Denied.

3. Admit that Humana Military Health Services, Inc. was mandated by the federal government to impose CMAC fee schedules on network hospital outpatient radiology and laboratory services for services rendered before October 1, 1999. Response: Admitted.[21]

These responses leave little doubt that at least as of April 2008 Humana, without equivocation, took the position it was mandated by the federal government to impose CMAC fee schedules on Plaintiffs effective October 1, 1999. Consequently, this issue was [and is] a disputed issue in this case and thus ripe for disposition in a motion for partial summary judgment. Humana's concession in its response to the motion does not moot the issue or make the issue immaterial. Rather, the concession simply results in the granting of the motion. Humana's concession on this issue makes sense because Humana's position that it was mandated by the federal government to change the reimbursement policy effective October 1, 1999 is at odds with decisional authority by this Court and by the Sixth Circuit and is not supported by the evidence in the record before this Court.

The view that Humana was mandated to make the change in payment policy was rejected by this Court in the earlier related case of Bd. Of Trustees of Bay Medical Ctr. et al. V. Humana Military Healthcare Services, Inc., Case No. 5:30-cv-144-MCR

[21] Defendant Humana Military Healthcare Services, Inc.'s Response to Plaintiff's First Requests For Admission, served on April 20, 2008. Doc. 411, Ex. 21.

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(N.D.Fla. March 16, 2004) and by the Sixth Circuit Court of Appeals in Baptist Physician Hopsital Organization, Inc. v. Humana Military Healthcare Services, Inc., 368 F.3d 894, 899-900 (6th Cir. 2004).

In Bay Medical Center this Court examined the arrangement between the government, Humana (the MSC contractor) and the network providers and concluded that Humana, as a MSC contractor, was permitted to pay network providers beyond the Government's allowed amounts, implicitly recognizing that Humana was not mandated by the federal government to limit the amount paid to the network provider. Similarly, in Baptist Physician Hospital the Sixth Circuit held that Humana was not under any federal mandate to limit payment to a network provider to the government allowable amount. The Court there concluded "that federal regulations and associated TRICARE policies incorporated in the parties' agreement by reference do not categorically bar an independent managed care support contractor, such as Humana, from paying sums in excess of government allowables on certain claims." Id. at 899-900.

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The record evidence also demonstrates that the federal government did not mandate that Humana change the reimbursement policy effective October 1, 1999. This, of course, is a different issue from the issue of whether TMA policy permitted alternative network reimbursement methodologies. This issue is the subject of Humana's Motion for Summary Judgment and will be addressed later in the section of the report and recommendation addressing that motion. However, for purposes of this Federal Mandate Motion the narrow issue is simply whether Humana was directed or mandated by the federal government to change the rate to the CMAC effective October 1, 1999.

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Humana announced the change in payment policy in a November 18, 1999 letter from Richard J. Mancini, Director of Humana Network Development to each of the Plaintiff/hospitals.[22] Prior to the date of the Mancini letter announcing the change in policy, the evidence is not in dispute that Humana had requested permission from the TMA to change the rate for hospitals from billed charges to CMAC rates and the TMA did not mandate or direct Humana to change the payment method. Indeed, the evidence suggests the contrary.

For example, on September 23, 1998, Dr. John E. Crum, the Chief Medical Officer for Humana, wrote a letter to the TMA contracting officer advising that Humana wanted to apply the CMAC fee schedules to reimburse network provider hospitals for radiology, laboratory and other outpatient diagnostic services.[23] The TMA contracting officer advised Humana in a December 1, 1998 letter in response to Humana's September 23, 1998 letter that the TMA needed more information and Humana should continue to operate under current guidelines, which in December 1998 continued to be payment of billed charges.[24]

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As further evidence that Humana was not mandated by the federal government to change the reimbursement method, in May 1999 Humana submitted a Value Engineering Change Proposal to the government suggesting that its contract be changed from payment based upon billed charges to allow payment for hospitals based

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[22] Doc. 210, Defendant's Ex. 163.

[23] Doc. 411, Ex. 31.

[24] *Id.*, Ex. 32.

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upon the physicians' CMAC rates.[25] Rather than advising Humana that TMA's policy required the use of CMAC rates, the TMA simply responded that it needed more time to consider the proposal.[26] In September 1999 - just one month before Humana changed the reimbursement to the CMAC rate – the government wrote Humana a letter advising that the government's review of Humana's proposal revealed a lack of legislative authority for Humana's request to change the reimbursement method.[27] Ultimately, in March 2000 the TMA rejected Humana's proposal stating that it was not in the best interests of the government.[28] Thus, there is little doubt that as of October 1, 1999, when the reimbursement policy was changed from billed charges to the CMAC rate, the TMA had not mandated or directed Humana to change the policy.

Accordingly, because there is no evidence of record to suggest that the TMA or any other governmental entity mandated or directed Humana to change the reimbursement policy on October 1, 1999 to apply CMAC fee schedules for hospital outpatient services – an issue that Humana does not dispute – Plaintiffs' Motion For Partial Summary Judgment On Issue Related to Alleged Federal Government Mandate (Doc. 405) is due to be granted. Therefore, pursuant to Rule 56(g) of the Federal Rules of Civil Procedure, because there is no genuine dispute on the issue it is established for purposes of this litigation that the federal government did not mandate in October 1999 that Humana pay the hospitals lower rates based upon the CMAC fee schedules.

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[25] *Id.*, Ex. 33.

[26] *Id.* Ex. 37, TMA May 21, 1999 letter to Humana

[27] *Id.*, Doc. 40.

[28] *Id.*, Doc. 42.

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C. ***Humana Military Healthcare Services, Inc.'s Motion For Partial Summary Judgment***

A proper understanding of Humana's motion requires the Court to define the narrow and specific relief Humana requests in its motion and the relief it does not request. The limited issue rased by Humana in it motion is whether, from October 1, 1999, through April 30, 2009 the CHAMPUS/TRICARE allowable charge for outpatient non-surgical services rendered by the Plaintiff/network provider hospitals was the lesser of CMAC rates, network discounts, or billed charges. Humana contends that this factual issue is ripe for resolution by the Court because each of the network provider agreements at issue in this case incorporates in various ways the CHAMPUS/TRICARE allowable charge, as specified by the TMA, for outpatient non-surgical services rendered by the plaintiff/network hospitals. Humana reasons that the allowable charge operated as a contractual limit on each hospital's reimbursement for the disputed services. Humana is not requesting, however, that the Court address whether each contract incorporated the CHAMPUS/TRICARE allowable charge because these questions can only be addressed on a hospital-by-hospital, contract-by-contract basis after discovery is completed.

As support for its position, Humana argues that the TMA has now definitely taken the position that 'allowable charge" for the disputed services means the *lesser* of CMAC rates, network discounts, or billed charges. Humana then surmises that because the TMA has now announced a position consistent with Humana's view the Court must afford controlling weight to the view of the TMA. Humana goes on to argue that the TMA's position is fully supported by the applicable policy statements.

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There are several problems with the premise of Humana's argument. First, while Humana in its motion takes the position that the Court does not need to address the terms of the individual network provider contracts, Humana, nonetheless, asserts that each of the network provider agreements incorporates in various ways the CHAMPUS/TRICARE allowable charge. This assumption is not accurate. Not all of the network provider agreements entered into by Plaintiffs mention the term "CHAMPUS allowable." Second, the policy statements and regulations issued by the TMA do not fully support Humana's interpretation. Finally, even assuming the Plaintiffs agreed to be bound by TMA's reimbursement methodologies – and even assuming such methodologies include payment limitations for network providers – TMA's interpretation of "allowable charge" is not entitled to controlling weight.

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1. The Term CHAMPUS Allowable Does Not Necessarily Present a Common Factual Issue

Humana contends that because each of the network provider agreements in issue in this case incorporates "in various ways" the CHAMPUS/TRICARE "allowable charge" for outpatient non-surgical services – and the allowable charge operated as a contractual limit on each hospital's reimbursement – the Court is presented with a common factual issue for resolution.

According to Humana, a clause "substantially similar" to the following clause appears in "many" of the provide agreements:

> Notwithstanding the above, Hospital [agrees] that in no event shall payments made for medical services provided to Beneficiaries exceed one hundred percent (100%) of any CHAMPUS allowable (e.g. DRG, CMAC, or billed charges).

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Thus, Humana says because all of the provider agreements required the Plaintiffs to "abide by all TRICARE policies and procedures, which include the allowable charges specified by TMA" the Court can and should resolve the common factual issue of what amount TMA specified as the allowable charge during the relevant period.

Not all of the provider agreements, however, present a common question of fact on this point. For example, the Tenet Florida contract defines the term "CHAMPUS allowable" to mean the hospital billed charges.[29] The Phoebe Putney Hospital contract contains express payment rates which apply CHAMPUS DRG rates to inpatient services, a percentage of CMAC rates for physician services, and a percentage of "CHAMPUS allowable" for hospital outpatient services.[30] This language on its face suggests that "CHAMPUS allowable" means something different from CMAC and not limited by CMAC, as Humana suggests. Further, the Our Lady of the Lake Hospital provider agreement does not even include the "notwithstanding" clause relied upon by Humana for its argument that CHAMPUS allowable was a limit on reimbursement.[31]

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The fact that there is not a common issue of fact as to what amount TMA specified as the "allowable charge" during the relevant period is underscored in the Eleventh Circuit's decision reversing class certification in this case. In describing the disparities in the contract payment terms the Eleventh Circuit observed:

> [T]here can be no dispute that those clauses [the payment clauses] contain a wide variety of language.... [i]t is enough to observe that some of the contracts contain unqualified reference to billed charges or a flat

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[29] Doc. 345, Ex. 9.

[30] *Id.*, Ex. 5.

[31] *Id.*, Ex. 4.

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> rate, others limit payment to "any CHAMPUS allowable" and are accompanied by a parenthetical phrase containing one or more such "allowables," still others make partial or exclusive reference to CMAC, and a number of others contain language unique to themselves.

Sacred Heart Health Systems, Inc. V. HumanaMilitary Healthcare Services, Inc., 601 F.3d 1159, 1167 (11th Cir. 2010).

Indeed, in its appeal of the Court's order granting class certification Humana conceded that "certain of the contracts contained ambiguities which, under the laws of each of the six relevant states, would require recourse to extrinsic evidence of the parties' pre-and-post contract negotiations and dealings[.]" Id. at 1168. Thus, while the TMA may have officially opined now on the meaning of "allowable charge," it is questionable whether a summary judgment acknowledging TMA's definition as a matter of undisputed fact would be appropriate outside of the context of interpreting a particular contract under the applicable state's law.

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2. *The Applicable Regulations Do Not Support The Interpretation That the CHAMPUS/TRICARE Allowable Charge for Outpatient Non-surgical Services Was the Lesser of CMAC, Network Discounts, or Billed Charges*

Although the TMA's most recent official interpretation is that the CHAMPUS/TRICARE allowable charge for outpatient non-surgical services was the lesser of CMAC, network discounts, or billed charges, the applicable regulations do not, on their face, support that interpretation.

The regulations were promulgated pursuant to 10 U.S.C. § 1079(j), which provides in relevant part that: "[t]he amount to be paid to a provider of services for services provided under a plan covered by this section shall be determined under joint regulations ... " The provider reimbursement methods for CHAMPUS providers is

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established in the regulations in 32 C.F.R. § 199.14. Specifically, § 199.14(a) governs "Hospitals," and provides for four reimbursement methods: (1) CHAMPUS Diagnosis Related Group (DRG), applicable to inpatient hospital services; (2) CHAMPUS mental health per diem payment system; (3) "Billed charges and set rates" for hospital care not subject to the first two methods; and (4) CHAMPUS discount rates. The third subsection is the one in issue in this case.

Section 199.14(a)(3) limits reimbursement to the lower of "(i) the actual charge for such service made to the general public; or (ii) the allowed charge applicable to the policyholders or subscribers of the CHAMPUS fiscal intermediary for comparable services under comparable circumstances ... ; or (iii) the allowed charge ... as established by local or state regulatory authority, excluding title XIX of the Social Security Act or other welfare program[.]" Notably, there is no specific reference whatsoever in § 199.14(a)(3) to CMACs.

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In contrast, § 199.14(h) – which governs reimbursement of individual health care professionals and other non-institutional providers – makes specific reference to CMAC as a component of the "allowable charge method." Thus, the regulations expressly contemplate CMAC rates as a provider reimbursement method for physicians but not for hospitals.

Moreover, 32 C.F.R. §§ 199.17 *et seq.* – the regulations which specifically relate to the TRICARE program – contemplate that the reimbursement system for the TRICARE managed care system can deviate from the CHAMPUS reimbursement system. Specifically, § 199.17(p)(6), applicable to "civilian provider networks," establishes "[s]pecial reimbursement rates and methods different" from those

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established in § 199.14. Thus, under this regulation reimbursement methods may be expressed in terms of percentage discounts off of CHAMPUS allowable amounts, or in other terms. This interpretation of the CHAMPUS/TRICARE regulations is consistent with the view expressed by the Sixth Circuit in Baptist Physician Hospital Organization, 368 F.3d 899-900 in which the Sixth Circuit found that the intent of § 199.17(p)(6) was to "[p]rovide regional managed care contractors the flexibility to negotiate reimbursement methods that vary from the payment provisions established by regulation." 368 F.3d at 900. The Sixth Circuit there concluded that federal regulations and TRICARE policies do not categorically bar an independent managed care support contractor from paying sums in excess of government allowables on certain claims. Id. Although Baptist Physician Hospital concerned the effect of CHAMPUS/DRG rates for inpatient services – and not as here CHAMPUS rates for outpatient services – the Sixth Circuit's reasoning in Baptist Physician Hospital is even more persuasive in this case because "CHAMPUS/TRICARE allowable charge" – unlike "CHAMPUS/DRG – is nowhere expressly defined in the regulations.

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This view also is further supported by this Court's decision in Bay Med. Ctr., Case No. 5:30-cv-144-MCR (N.D.Fla. March 16, 2004) in which this Court concluded in interpreting Humana's contract with TMA that Humana could distribute funds it received under the contract to network providers as Humana saw fit, and could pay network providers an amount above the Government allowed amounts, provided that such coverage was paid out of Humana's administrative portion of its allotment.

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Accordingly, the Court concludes that the applicable regulations do not support Humana's interpretation that the CHAMPUS/TRICARE allowable charge for outpatient non-surgical services was the lesser of CMAC, network discounts, or billed charges.

3. TMA's Interpretation of "Allowable Charge" Is Not Entitled to Controlling Weight.

Relying upon TMA's recent testimony in this case that the CMAC rates were established for network providers prior to October 1, 1999, Humana contends that there is now no question concerning Humana's interpretation of TRICARE reimbursement policy. Humana concludes that because the TMA's testimony represents the agency's definitive position on the relevant TRCIARE reimbursement policies there is no dispute in this case and Humana is entitled to partial summary judgment in its favor.

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Although Humana does not expressly say so the premise of Humana's argument is that the Court should accord controlling weight to the testimony and official position taken by the TMA during its deposition in this case. There are two problems with Humana's argument. First, TMA's own interpretation of the reimbursement policy blurs the line between reimbursement methods for *non-network* providers and *network* providers. Second, because the TMA's interpretation relies upon policy statements, agency manuals and enforcement guidelines – and is not consistent with earlier pronouncements – the TMA's interpretation is not entitled to *Chevron or Skidmore* deference.

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In the Rule 30(b)(6) deposition of the TMA conducted in this case, the TMA designated Barbara Gallegos, a retired, career civil servant who worked for the TMA for 30 years, as the official to testify pursuant to a *Touhy* request under 32 C.F.R. §

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97.6(c)(2).[32] In summary, Ms. Gallegos testified that from at least October 1, 1999 through April 20, 2009, the "CHAMPUS/TRICARE allowable charge" for the services at issue in this case was the lesser of CMAC, network discounts, or billed charges.[33] The CHAMPUS/TRICARE allowable charge was a mandatory limitation applicable to both network hospitals and non-network hospitals.[34] In December 1998 TMA confirmed to Humana that claims for outpatient services described using HCPS coding should be reimbursed under CMAC, "consistent with TRICARE policy."[35] Humana advised TMA in August 1999 that Humana intended to begin limiting reimbursement of hospitals to CMAC and TMA did not object.[36] TMA believed that Humana's notification to the provider hospitals accurately described TMA policy and at various points in time after the payment method was changed by Humana TMA informed a number of hospitals that Humana's understanding of TRICARE reimbursement policy was correct.[37]

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Humana contends that Ms. Gallegos' interpretation is consistent with TMA's March 10, 2000 Policy Statement, which provided in relevant part that when "a claim has sufficient HCPCS ... coding information, services are to be processed using existing allowable charges. These services could include professional services that have CMAC

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[32] Doc. 437, Ex. E.

[33] Doc. 417, Ex. A, Tab 85.

[34] Id. at Tab 47.

[35] Id. at Tabs 51-52.

[36] Id. at Tabs. 53, 56.

[37] Id. at Tabs 57, 88.

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pricing." [38] Thus, so says Humana, the reference in the March 10, 2000 Policy Statement to "existing allowable charges" meant CMAC rates, and the reference to "professional services" encompassed both the technical and the professional components of hospital outpatient services ordered or rendered by physicians. Humana suggests that the March 2000 Policy Statement was not new, but merely clarified "existing policy." After the March 2000 Policy Statement , the DoD published an "Interim Final Rule" in June 2002 clarifying that CMAC rates were the limit for outpatient non-surgical services that had applicable HCPCS codes. In 2003 TMA further clarified the March 2000 Policy Statement, reconfirming that CMAC rates should be used for services that have such rates. In October 2005, the DoD issued a Final Rule clarifying "existing policy" that CMAC rates were the allowable charge for hospital outpatient services that had such established charges. Lastly, Humana contends that other contemporaneous communications from TMA to Humana and other parties were consistent with TMA's deposition testimony regarding limitation of reimbursement to CMAC rates.

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As Plaintiffs appropriately point out, however, TMA's interpretation blurs the line between reimbursement methods for *non-network* providers and *network* providers. For example, TMA's own Operations and Policy manuals provided that *network* providers could be paid based on other payment methodologies.[39] "The contractors and network providers [were] free to negotiate any mutually agreeable reimbursement mechanism

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[38] Id., Ex. B, Tab B-7J.

[39] Doc. 406, ¶¶ 44 and 45.

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which complies with state and federal laws."[40] On this issue there is not much of a dispute.

Nor is there any serious dispute of what TMA's current interpretation is today as expressed in Ms. Gallegos' deposition. The issue, however, is not what the TMA says is the correct interpretation but rather whether the Court is required to adopt the TMA's current expression of the policy. While Humana's reliance upon the TMA's current interpretation is justified, relevant case law suggests that the Court should afford the TMA's interpretation with only limited deference. Here's why.

The Supreme Court has stated that ordinarily "policy statements, agency manuals, and enforcement guidelines, all of which lack the force of law [ ] do not warrant *Chevron*-style deference." Christensen v. Harris County, 529 U.S. 576, 587 (2000) (adopting *Skidmore* deference instead for an agency opinion letter). The Christensen court explained that the agency opinion letter there had not undergone any formal adjudication or notice-and-comment rulemaking. Thus, the "rigors of the Administrative Procedure Act, including public notice and comment" which would warrant greater deference did not apply. Id.

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In this case it is undisputed that the TMA's recent interpretation of the CMAC reimbursement policy is not the result of notice-and-comment rulemaking, but rather is woven together from past policy statements and communications with its MCS

[40] Id., ¶ 44 (September 13, 1999 Operations Manual)

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contractors and the hospital providers. Thus, the Court should not afford Chevron[41] deference to the TMA's position.

Moreover, the Court should not afford Skidmore[42] deference to the TMA's interpretation of the CMAC reimbursement policy for outpatient services. The determination of whether a court should give "some deference" under Skidmore depends upon the "thoroughness evident in its consideration, and all those factors which give it power to persuade, if lacking power to control." Pugliese v. Pukka Development, Inc., 550 F. 3d 1299, 1305 (11th Cir. 2008)(*quoting* Buckner v. Florida Habilitation Network, Inc., 489 F. 3d 1151, 1155 (11th cir. 2007)). Further, where an agency adopts a "mere litigating position" the Court is not required to afford the position any deference. U.S. Steel Mining Co., LLC v. Director, OWCP, 386 F. 3d 977, 986 (11th Cir. 2004)("we do not afford deference to *ad hoc* positions of agencies adopted in reaction to the exigencies of litigation; rather, deference is due when an agency has taken a constant and unchanging – and reasonable – position on the proper interpretation of its regulation."

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In this case, the TMA's interpretation falls short of a position that should merit Skidmore deference because while the TMA may have given the matter thorough consideration over the years, the TMA's reasoning is not expressly validated in the CHAMPUS/TRICARE regulations, and the pronouncement of its interpretation has been piecemeal, expressed in policy manuals and in correspondence, at least until the

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[41] Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 842-844 (1984)(holding that a court must give effect to an agency's regulation containing a reasonable interpretation of an ambiguous statute)

[42] Skidmore v. Swift & Co., 323 U.S. 134 (1944).

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regulations were amended. Further, although TMA is not a party to this case, it clearly has a direct financial stake in the outcome of the litigation as evidenced by the fact that Humana has made demands on the government to pay Humana large sums of money based upon the various Value Engineering Change Proposals that Humana has submitted to the government beginning in 1999 and most recently in Humana's August 12, 2008 demand letter.[43] Under these proposals any savings resulting from a lower reimbursement rate is shared equally by Humana and the government. Thus, if the Court was to adopt Humana's view it would not only benefit Humana but arguably would have a favorable impact financially on the government. While the Court recognizes that the TMA is not a party to this case it is nonetheless reasonable to view the TMA's interpretation of the reimbursement rate as a litigating position not entitled to controlling weight.

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In sum, although there is no dispute that the TMA's recent testimony expresses its official view of the reimbursement rate, the TMA's testimony is not entitled to controlling weight in the interpretation of the "allowable charge" language at issue in the network provider contracts between Humana and the Plaintiffs.

Accordingly, for these reasons – and on the narrow issue presented by Humana in its motion – Humana is not entitled to partial summary judgment on the issue that the CHAMPUS/TRICARE allowable charge from October 1, 1999, through April 30, 2009 for outpatient non-surgical services rendered by the Plaintiff/network provider hospitals was the lesser of CMAC rates, network discounts, or billed charges.

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[43] *See,* Doc. 475, Ex. 7 (filed under seal).

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D. Right to Litigate Individual Claims Motion

Plaintiffs seek an order declaring that Humana cannot now litigate the underlying validity of individual benefit claims which been paid in part. Plaintiffs' position is straightforward. Plaintiffs argue that because the claims already have been submitted, processed and paid the claims have been determined to be "clean claims" and thus there is no right to go back and reexamine these claims. Thus, according to Plaintiffs, Humana has waived any challenge to the validity of the individual claims or, alternatively, is estopped from challenging the validity of the claims.

While in a general sense there is superficial appeal to Plaintiffs' argument, Plaintiffs' position ignores the fact that the Plaintiffs have the burden of proof in this case of establishing an entitlement to payment. Further, in arguing that the only issue – and thus the only proof required in this case – is the claim forms submitted by Plaintiffs, Plaintiffs conflate the evidentiary issue of whether they may prove their claims through summaries with the issue of whether Humana is entitled to go behind the claims form to determine whether Plaintiffs are entitled to payment for the particular claim. Lastly, because Plaintiffs have placed in issue the payments they already have received Humana has a legal right to seek recoupment of any claims already paid, even if such a request would have been too late if Humana had asserted such claims in an independent action.

As a starting point in the analysis it is necessary to understand the meaning of a "clean claim" and the review process undertaken by Humana upon submission of a claim.

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For each claim involved in this case, Plaintiffs submitted a UB-92 or UB-04 claim form. Plaintiffs prepared these claim forms from clinical records that were created by the professionals who rendered the particular medical service. The forms are completed using a series of coding rules the purpose of which is to translate the information in the clinical records into Healthcare Common Procedures Coding System ("HCPCS") codes and other alphanumeric coding systems used for claims processing. Because claims forms are submitted using codes there is always a possibility for coding errors. Further, because the clinical records are not submitted with the claims forms the MSC contractor, like Humana, does not determine before it pays a claim whether the clinical records accurately document the coding on the claim forms or even whether the services were actually performed.

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The TRICARE Operations Manual only requires Humana to review the claim prior to payment to ensure that sufficient information appears on the face of the claim form to determine whether: the patient is eligible; the provider of services is authorized under the TRIACARE program; the service of supply noted on the face of the form is a benefit; the service is medically necessary and appropriate or is an approved TRICARE preventive care service; the beneficiary is legally obligated to pay for the service; and the claim form contains sufficient information to determine the allowable amount for each service.[44] Assuming a claim form contains this required information the claim is considered a "clean claim" and Humana then is required to pay the network provider for

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[44] Doc. 410, Ex. 11.

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the services identified in the claim form.[45] The determination that a claim is a "clean claim," however, does not mean that the claim form was accurately coded, that the claim form accurately describes the actual services that were performed, that the services were ordered by a licensed health care professional, or that the services described on the claim form were actually performed.[46] Thus, the prepayment review of the claim forms does not include a review or determination concerning the validity of the underlying service but only that the information on the face of the claim form entitles the service provider to payment.

There also are procedures available to MCS contractors, like Humana, for review of claims after payment to providers to verify that only legitimate claims are being paid and that accurate payment is being made. These post payment audits permit Humana to test the representations in the claim forms against the underlying clinical records and then if appropriate to recoup any overpayments it discovers. [47]

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According to Plaintiffs, because Humana determined in the claim review process that the claims in this case were "clean" and because Humana had available procedures for post payment audits – which either were not utilized or did not reveal improprieties – Humana cannot now go back and reexamine the "clean claims." Plaintiffs' position taken to its logical extreme would mean that because the claim review process has been completed and payments have been made on those claims

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[45] The term "'clean claim' means a claim that has no defect, impropriety or particular circumstance requiring special treatment that prevents timely payment on the claim under this section [subsection (a)]" 10 U.S.C. § 1095c(a)(3).

[46] *See,* Doc. 439, App. L ¶16; App. M ¶¶30-31.

[47] *Id.* App. L, ¶¶ 50-51, 53; App. M, ¶¶ 16-18, 22, 32-33.

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not only would Humana be prohibited from going back and opening-up the paid claims but Plaintiffs as well would be precluded from going back and opening-up the claims, even for the under payments as alleged by Plaintiffs in this case. Simply put, if the claims are final and not subject to further review or legal challenge by any party neither the Plaintiffs nor the Defendant would be entitled to reopen any of the claims and neither party would be entitled to any relief. That is not the case. Just as Plaintiffs may be entitled to seek reimbursement under a theory of breach of contract for payment of additional amounts on each clean claim so too may Defendant seek recoupment of any amounts it has paid which are not legitimate.[48]

Because Plaintiffs seek additional reimbursement for the clean claims for which they already have been paid, there is little issue that the accuracy of those claims has been placed directly in issue.[49] The nationally recognized case of In re Managed Care Litig., 209 F.R.D. 678 (S.D. Fla. 2002) from the Southern District of Florida is highly

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[48] This does not mean that the Defendant cannot challenge Plaintiffs' breach of contract claims based upon statute of limitations, estoppel, waiver or other applicable affirmative defenses. These issues are not before the Court on the pending motions for summary judgment. Moreover, the resolution of the defenses of estoppel or waiver would have to be made on a contract by contract - hospital by hospital basis and not generally as applied to all of the plaintiff hospitals. Indeed, one of the reasons the Eleventh Circuit decertified this case as a class action is because of the individualized nature of these defenses.

[49] Plaintiffs' suggestion that Defendant should not be permitted to litigate the validity of the individual claims because Defendant has not proffered any evidence that there is a problem with any of the claims is not very persuasive. Plaintiffs have vigorously resisted during discovery producing any underlying records relating to the claims. It is incongruous to argue that Defendant cannot point to any particular claim and at the same time refuse to provide the very documentation that Plaintiffs contend is absent. Secondly, while Plaintiffs argue that they will be able to prove their case through the use of summaries rather than through use of individual claim forms, this argument ignores the fact that under Rule 1006 of the Federal Rules of Evidence, Defendant will be entitled to examine the underlying documents, which in fairness may include not only the claim forms but the back-up documents to the claims form. Lastly, Defendant points to the fact that at least one of the Plaintiffs – the Tenet Healthcare Corporation – was involved in a $900 million settlement of a False Claims Act case which included among other allegations that the hospitals there submitted outpatient claims to the CHAMPUS/TRICARE program for "services not provided to patients." *See,* Doc. 439, App. Q, Tabs 9, 10 & 11.

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instructive on this issue. Thousands of doctors in In re Managed Care sued the nation's largest health insurers seeking payments for services rendered by the doctors to insureds under the health plans. The health insurers – like Humana in this case – sought discovery of clinical records in order to investigate the accuracy of the claim forms the doctors had placed in issue. Despite the fact that the doctors there argued that it was too late to dispute the accuracy of the claim forms, Judge Moreno ordered the doctors to produce the requested clinical records because those claims were in issue.[50]

Also instructive on this issue is the position taken by the arbitration panel, in an arbitration proceeding against Humana involving several hospitals not named in this case and involving the identical claims involved in this case. There the arbitration panel ordered the hospitals to produce the clinical records recognizing that the records were relevant to determining what services were actually performed under each claim.[51]

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Accordingly, because Plaintiffs have placed in issue the individual claims for which they were paid previously and Plaintiffs will be required to demonstrate that they performed the services identified in the individual claim forms – and not just that the Plaintiffs reported the services – as a matter of due process Defendant should be entitled to investigate and, if appropriate, seek recoupment of any monies paid to Plaintiffs for services not provided or for monies paid for services for which Plaintiffs were not entitled.

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[50] *See* orders at Doc. 439, App. Q, Tabs 2 & 3.

[51] *See,* Glynn-Brunswick Mem'l. Hosp. Auth. v Humana Military Healthcare Servs. Inc.. Doc. 439, App. Q, Tab 4.

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The fact that Humana seeks to challenge the validity of individual claims years after the claims were reviewed and paid is not a sufficient legal basis to prevent Humana from attempting to litigate the validity of the claims. The law is well settled in each of the relevant states in this case that a party may assert a compulsory counterclaim for recoupment for money damages even where the claim may be barred by the statute of limitations. *See, e.g.* Allie v Ionata, 503 So. 2d 1237, 1240 (Fla. 1987)("A party who seeks affirmative relief, whether through an original complaint or a counterclaim, effectively asserts that he is prepared to prosecute all aspects of that matter. Having sufficient knowledge of the facts to support a complaint and sufficient evidence to prosecute that complaint, he must be prepared to defend against any affirmative defenses arising therefrom."); Blasland, Bouch & Lee v. City of Miami, 283 F.3d 1286-1300-1301 (11th Cir. 2002)("Even assuming that the [defendant] did bring its counterclaim after the statute of limitations had run, under Florida law that counterclaim would not be time-barred if it was a compulsory counterclaim for recoupment of money damages."); Romar Dev. Corp. v. Gulf View Mgmt. Corp., 644 So. 2d 462, 473 (Ala. 1994); Hodge v. Cmty. Loan & Inv. Corp. Of N.Ga., 210 S.E. 2d 826, 831-32 (Ga. Ct. App. 1974)("As long as the plaintiff has a legal right to sue on the notes, the defendants would have a correlative right to defend; and the plaintiff could not insist upon the statute of limitation in order to avoid the defendants' defense, while seeking to enforce the contract against him."); La. Code Civ. Pro. Ann. Art. 424 ("a prescribed [time-barred] obligation sought under Louisiana law may be used as a defense if it is incidental to, or connected with, the obligation sought to be enforced by the plaintiff."); Gerald v. Foster, 168 So. 2d 518, 524 (Miss. 1964)(("the fact that the defendant's items of setoff may

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have been barred by the statute of limitation at the time the plea of setoff was filed did not preclude the [defendant] from using the items as a setoff against the debt sued on."); Wood v. Cannon Cnty., 166 S.W. 2d 399, 401 (Tenn. Ct. App. 1942)(recognizing that "the statute of limitations does not run against a matter which arises out of the plaintiff's cause of action and which is set up as a recoupment or defense against his suit."). Thus, when Plaintiffs decided to sue on claims that were paid and resolved years ago, Plaintiffs left themselves open to all compulsory counterclaims and defenses - whether time barred or not – seeking recoupment for monies previously paid which Plaintiffs were not entitled to receive.

Moreover, Plaintiffs' request for summary judgment on the basis that Humana has waived its right to assert the validity of individual claims or that Humana is equitably estopped from challenging the validity of the individual claims also fails. Relying upon the Court's equity jurisdiction Plaintiffs suggest that because Humana not only had the right but the obligation to review the documents supporting the individual claims submitted by the plaintiff hospitals, Humana has waived its claims in this case by failing to do so during the claim submission and review process. Pointing to Humana's same failure to review the back-up to the claims when they were submitted and Humana's payment on the claims, Plaintiffs argue that Humana is equitably estopped from contesting the validity of the individual claims because Humana's position in this case is different from its position when the claims were reviewed and paid. Lastly, relying upon

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several state prompt payment statutes,[52] Plaintiffs contend that Humana waived its right to seek recoupment of any alleged overpayments.

The primary flaw in Plaintiffs' waiver and equitable estoppel argument is that these defenses to Humana's counterclaim, by their very nature, are fact specific to each network provider agreement on a hospital-by-hospital basis. The information presented by each Plaintiff hospital as to each claim form and in turn what representation or response was made by Humana to the claim must be determined on an individual basis and not, as Plaintiffs suggest, based upon general statements of the claims review process. A critical element of any claim of equitable estoppel requires proof that the party invoking it must show that he or she relied upon the other party's conduct to his or her detriment or prejudice and that the party to be estopped acted in such a way as to induce reasonable reliance by the other party. *See, e.g.* Reform Party of Alabama v. Bennett, 18 F.Supp.2d 1342 (M.D. Ala. 1998)("Detrimental reliance is a necessary element of the doctrine of equitable estoppel."); Soutgheast Grove Management Inc. v. McKiness, 578 S0. 2d 883, 886 (Fla. Dist. Ct. App. 1991)(""Equitable estoppel generally consists of words or conduct which causes another person to believe a certain state of things exists, and to consequently change his or her position in an adverse way.").

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[52] See, e.g. § 627.6131(6)(1)1., Fla. Stat. (2010)("All claims for overpayment must be submitted to a provider within 30 months after the health insurer's payment of the claim."); Ala. Code § 27-1-17(e)(2010)(Stating that a claim to retroactively adjust or seek recoupment of a paid claim cannot be made "after the expiration of one year from the date that the initial claim was paid or after the expiration of the same period of time that the health care provider is required to submit claims pursuant to a contract between the health care provider and an insurer, whichever date occurs first."); LSA-R.S. § 22:1834 C. (2010)("A health insurance issuer that prescribes the period of time that a health care provider under contract for provision of health care services has to submit a claim for payment under R.S. 22:1832[non-electronic] or 1833 [electronic] shall have the same prescribed period of time following payment of such claim to perform any review or audit for purposes of reconsidering the validity of such claim."); T.C.A. § 56-70-110(c)("Except in cases of fraud committed by the health care provider, a health insurance entity may only recoup reimbursements to the provider during the eighteen-month period after the date the health insurance entity paid the claim submitted by the health care provider.");

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Thus, the conduct of the party claiming an estoppel must be considered no less than the conduct of the party sought to be estopped. Consequently, Plaintiffs would have to demonstrate on a hospital-by-hospital basis that Humana represented it did not intend to take any further action on the claims when it paid the claims and in reliance on those representations Plaintiffs detrimentally relied or took some adverse action. Plaintiffs have not argued in their motion – nor have they submitted any evidence – that Humana did anything (other than pay the claims) which could be interpreted as conduct intended to induce a plaintiff/hospital not to take action or to take some affirmative action it would not have taken.

The same applies to Plaintiff's common law waiver argument. Waiver requires proof of the intentional or voluntary relinquishment of a known right or conduct which warrants an inference of the relinquishment of a know right. *See, e.g.* Dooley v. Weil, 672 F.2d 1340, 1347 (11th Cir. 1982); Citizens Property Ins. Corp. v. Michigan Condominium Ass'n., 46 So. 3d 177, 178 (Fla. Dist. Ct. App. 2010). While waiver may be implied from conduct, nonetheless, there must be conduct evidencing an intention to waive a right. Other than the fact that Humana did not seek recoupment as part of the claims review and audit process, Plaintiffs fail to point to any evidence suggesting conduct by Humana that it had relinquished its right to seek recoupment. Moreover, evidence of conduct demonstrating waiver would have to be made on a contract-by-contract and hospital-by-hospital basis and not simply by reference to the fact that Humana did not seek recoupment during the claims review and audit process.

Lastly, Plaintiffs' argument that the various state prompt payment statutes bar Humana from asserting claims for overpayment on individual claims can be disposed of

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easily. Because the relevant state prompt payment statutes by their own terms are directed to "health insurance, prepaid health plans, or other health care delivery ... methods," these types of state laws are expressly preempted by and are not applicable in connection with TRICARE regional contracts. 32 C.F.R. § 199.17(7)(ii)("[a]ny State or local law relating to health insurance, prepaid health plans, or other health care delivery or financing methods is preempted and does not apply in connection with TRICARE regional contracts. Any such law, or regulation pursuant to such law, is without any force or effect ..."). The reason state health care laws are preempted is set out expressly in the regulations. Section 199.17(7)(I) of Title 32 of the Code of Federal Regulations declares:

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> "[t]he Department of Defense has determined that the administration of 10 U.S.C. chapter 55, preemption of State and local laws relating to health insurance, prepaid health plan, or other health care delivery or financing methods is necessary to achieve important Federal interests, including but not limited to the assurance of uniform national health programs for military families and the operation of such programs at the lowest possible cost tot he Department of Defense, that have a direct and substantial effect on the conduct of military affairs and national security policy of the United States.

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Thus, because the state prompt payment statutes relied upon by Plaintiffs would interfere with the rights and obligations of MCS contractors, like Humana, in carrying out their obligations under the TRICARE regional contracts the prompt payment statutes do not govern the rights of MCS contractors to seek recoupment. Further, even assuming *arguendo* that the state prompt payment statutes were not preempted and therefore dictated the time period in which a health care delivery contractor such as Humana could seek recoupment from a health care provider under TRICARE, the prompt payment statutes do not alter the common law rule that a claim for recoupment

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can always be brought as a compulsory counterclaim even if the claim would be time barred if brought as an independent action.

Accordingly, for all of these reasons, Plaintiffs' motion requesting partial summary judgment in their favor finding that Humana cannot litigate the underlying validity of individual benefit claims which it has paid is due to be denied.

E. Plaintiffs' Motion for Summary Judgment With Respect to Humana's Counterclaim.

In this motion, Plaintiffs request summary judgment in their favor with respect to Humana's counterclaims for breach of contract (Count I) and for unjust enrichment (Count II). Plaintiffs' arguments – and Humana's response – are largely a rehash of arguments advanced previously by the parties in their respective motions for partial summary judgment addressed by the Court above.

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1. Breach of Contract Counterclaim

Specifically, with regard to Humana's counterclaim for breach of contract, Plaintiffs argue that Humana's breach of contract claim purports to allege two theories of breach. The first theory is that the Plaintiff/hospitals breached the network provider agreements by accepting any payments above what the network provider agreements provided. The predicate for this claim is Humana's argument that the hospitals should not be entitled to any increase either in the billed charges or, alternatively, the CMAC rates after the dates the network provider agreements were signed. Plaintiffs' receipt and retention of any payments above these amounts is, according to Humana, a breach of the network provider agreements. The second theory raised in Humana's breach of contract counterclaim is that the Plaintiff/hospitals breached the network provider

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agreements to the extent they received any payments based on billing errors or received payments for services that are not supported by the clinical records.

As to the first theory, Plaintiffs argue that Humana cannot establish a breach of contract because the plain wording of the agreements refutes the contractual limitation suggested by Humana. The problem with Plaintiffs' argument – which was the same problem with Humana's argument advanced in its motion for partial summary judgment – is that resolution of the issue of whether the network provider agreements contain a contractual limitation can be made only on a contract-by-contract and hospital-by-hospital basis. And while there may be some general similarities in the language used in groups of the network provider agreements, nonetheless, because most of the network provider agreements are different from hospital to hospital, and include changes in language on a yearly basis when the agreements were renewed, the determination of what is the applicable contractual language and then the interpretation of the meaning of the language must be made for each contract and only after discovery has been completed. As Humana conceded in its motion for summary judgment, whether the plaintiffs' individual contracts incorporated the maximum allowable amount suggested by Humana is a question that must be addressed on a "hospital-by-hospital, contract-by-contract basis.[53] Indeed, in Plaintiffs Opposition to Defendant's Motion for Summary Judgment Plaintiffs also readily recognized that resolution of claims for breach of contract would have to be made on an individual contract basis and could not be resolved without reference to the language in each

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[53] Doc. 416, p.1, 4.

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contract.[54] Despite recognizing that resolution of the applicable reimbursement rates would have to be made on a hospital-by-hospital, contract-by-contract basis Plaintiffs have presented a motion for summary judgment without addressing the individual contracts.[55] On this basis alone, Plaintiffs' Motion for Summary Judgment with respect to Humana's breach of contract counterclaim is due to be denied.

Similarly, Plaintiffs' motion for summary judgment with respect to the second theory of breach of contract also can be disposed of easily. The gist of Plaintiff's argument is that Humana's claim is defective because Humana has not included any specific references to particular claims that contain errors. Drawing upon the Twombly/Iqbal plausibility standard[56] for stating a cause of action, Plaintiffs argue that in addition to Humana's failure to assert well-pleaded facts in the counterclaim, Humana has failed to point to any facts in the record demonstrating any overpayments related to billing errors or unreasonable billing with respect to any of the paid clean claims. Plaintiffs summarize that because Humana has failed to establish the existence of an element essential to a claim upon which that party bears the burden of proof at trial there is no genuine issue as to any material fact and therefore Plaintiffs are entitled to summary judgment on the breach of contract counterclaim seeking reimbursement for billing errors.

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[54] Doc. 427, p. 10 n. 6. ("The individual contracts of the plaintiffs will be addressed in separate motions.)

[55] The only individual contract mentioned by Plaintiffs in their motion is the Parkway Regional Medical Center Hospital Participation Agreement. This contract is mentioned only to make the point that based on the particular language in that agreement Humana knew how to limit the billed charges to the rates applicable on the effective dates of the agreements. Doc. 449, pp.8-9.

[56] *See,* Ashcroft v. Iqbal, __ U.S. __, 129 S.Ct. 1937 (2009); Bell Atlantic Corp. v. Twombly, 550 U.S. 544, 127 S.Ct. 1955 (2007).

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To th extent Plaintiffs' argument is focused upon the allegations in Humana's counterclaim the argument fails because even under Rule 8(a) of the Federal Rules of Civil Procedure and under Iqbal Humana is not required to identify the precise claims Humana alleges are the target of its counterclaim for breach of contract.[57] Further, to the extent that Plaintiffs' argument is focused upon the lack of record evidence demonstrating particular clean claims, which allegedly were overpaid by Humana, the argument ignores the fact that (at least at the time Humana filed its response to Plaintiffs' motion) Humana did not have access to the clinical records supporting the claims and had not obtained any claims data or clinical records (based upon a sampling or otherwise) from the Plaintiffs. While Humana, as part of the review process, would have possession of (or access to) the claim form and any documents submitted with the claim form the clinical records are not submitted with the claim form. Thus, the primary-source clinical records from which the submitted claim forms were derived are not in the possession of Humana but rather are required to be maintained by Plaintiffs. Billing errors or payment for services not supported by clinical records can only be identified by examining the primary-source documents. There is no dispute that Humana requested this information during discovery and that at the time Humana's response was filed Plaintiffs objected to production of the primary-source documents. While the Court has now entered various orders addressing these discovery issues and implemented efficient methods of producing documentation based upon sampling,[58] the

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[57] Indeed, if that was the standard Plaintiffs' Fourth Amended Complaint would suffer from the same defect because Plaintiffs have not identified specific claims.

[58] *See,* Docs. 520, 521 & 537.

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fact remains that Humana did not have the necessary discovery to identify specific claims that contained billing errors.

Pursuant to Rule 56(d) of the Federal Rules of Civil Procedure, where, as here, a nonmovant shows that for specific reasons, it cannot present facts essential to justify its opposition, the Court may, *inter alia*, deny the motion.[59] The Court therefore concludes that Plaintiffs' motion for summary judgment on Humana's counterclaim is due to be denied for this reason.[60] To rule that Humana cannot demonstrate that there are specific claims containing billing errors without giving Humana an opportunity to examine in discovery the primary-source documents would violate Rule 56(d) and would reward Plaintiffs for resisting production of these documents in discovery.

2. Unjust Enrichment Counterclaim

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Plaintiffs request dismissal of Humana's counterclaim for unjust enrichment arguing that an action for unjust enrichment cannot lie in the face of an express contract. Humana counters that this general rule does not apply because Humana is entitled to plead in the alternative at least until the agreements at issue are held to be

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[59] While Humana did not file an affidavit or declaration (as required by the Rule) in making its showing that additional discovery is needed, the Court has more than sufficient information on the docket and in the voluminous filings made by the parties sufficient to identify the necessary discovery, the efforts made to obtain the necessary information and the relevance of the outstanding discovery to the motion for summary judgment. The Court therefore concludes that while the letter of the Rule might not have been satisfied the purpose and spirit of the Rule have been more than satisfied.

[60] Plaintiffs also suggest that the counterclaims for breach of contract should be dismissed because under various state prompt payment statutes the time for bringing claims to recoup overpayments has long since passed. Even assuming these prompt payment statutes were not preempted by federal law and were applicable, none of these state law limitations are applicable to the counterclaims because the law in each of the relevant states provides that affirmative defenses and counterclaims arising out of transactions a plaintiff places in issue are timely if the plaintiff's claims have been filed timely. *See, cases cited supra.* pp. 33-34.

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enforceable. Additionally, Humana suggests that because some plaintiffs left the network during periods relevant to this dispute the network agreements might not apply.

A claim for unjust enrichment is an equitable claim based upon a legal fiction created by courts to imply a contract as a matter of law. Tooltrend, Inc. v. CMT Utensili SRL, 198 F.3d 802, 805 (11th Cir. 1999). Because a claim for unjust enrichment by its very nature is based upon the concept that the parties rights and duties are not governed by provisions in a contract, where an express contract governs the relationship between the parties an action for unjust enrichment cannot be maintained. *See, e.g.*, Webster v. Royal Caribbean Cruises, Ltd., 124 F.Supp. 2d 1317, 1326 (S.D. Fla. 2000)("upon a showing that an express contact exists, the quasi contract claim fails.")[61]

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With respect to Humana's counterclaim based upon the theory that Plaintiffs accepted reimbursements above what the network provider agreements provided this claim falls squarely within the rule that a party cannot advance a claim for unjust enrichment where the provisions of an express contract determine the rights and obligations of the parties. Humana's theory is that the network agreements contain a contractual limitation on the reimbursement Plaintiffs were entitled to receive and the receipt and retention of reimbursement payments at rates above the contractual limitations entitles Humana to return of the monies. This is an issue of contract interpretation. If the network provider agreements say and mean what Humana contends then Plaintiffs may have breached the agreements. Conversely, if the network

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[61] *See* cases cited in Doc. 449, pp.22-24 referencing general rule of law in Florida, Alabama, Georgia, Mississippi, Louisiana and Tennessee that an implied contract will not be imposed in circumstances where an express contract or agreement exists.

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provider agreements do not say and mean what Humana contends and instead say and mean what Plaintiffs suggest then Humana has no right under the contracts to return of any of the payments and thus there cannot be a claim for unjust enrichment. Accordingly, as to this theory advanced in Humana's counterclaim Humana cannot plead in the alternative because as a matter of law a claim for unjust enrichment cannot supplant the express provisions of a contract.[62]

With respect to Humana's counterclaim for reimbursement for monies paid because of billing errors or because the primary-source documents do not support the claim for reimbursement, this claim may be pled in the alternative because the express provisions of the contract do not determine Humana's right to relief. The three elements required to state a claim for unjust enrichment are present in this situation: (1) plaintiff conferred a benefit on the defendant and their knowledge of such a benefit; (2) the defendant voluntarily accepted and retained the benefit; and (3) that circumstances would make it inequitable for the defendant to retain the benefit without just compensation. Nova Information Sys., Inc. v. Grennwich Ins. Co., 365 F.3d 996, 1006-07 (11th Cir. 2004). A claim for unjust enrichment applies to situations exactly like this where one party receives something of value to which it is not entitled and the terms of an express contract do not form the basis of the claim. *See, e.g.* Tracfone Wireless, Inc. v. Access Telecom, Inc., 642 F.Supp. 2d 1354, 1366 (S.D. Fla. 2009).

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[62] Humana's alternative argument that some plaintiffs left the network and therefore a claim for unjust enrichment is justified because there was no contract is not supported by the record. The only plaintiff referenced by Humana is The Medical Center. The record before the Court reflects that while The Medical Center's contract ended December 1, 2001 its claim in this case does not extend beyond that date as suggested by Humana. *See,* Docs. 459-1, 12, 460-1 through10 and 461-1 through 462-8.

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Accordingly, because Humana's counterclaim for unjust enrichment requesting recovery of payments made to Plaintiffs based upon billing errors or for payments made based upon charges not supported by the primary-source documents, is not dependent upon the express provisions of the network provider agreements, Plaintiffs' motion for summary judgment as to these claims in Count II of Humana's counterclaim for unjust enrichment is due to be denied.

IV. RECOMMENDATION

In view of the foregoing, it is respectfully **RECOMMENDED** that: (1) Plaintiffs' Motion For Partial Summary Judgment On Issue Related to Alleged Federal Government Mandate (Doc. 405) should be **GRANTED**; (2) Humana Military Healthcare Services, Inc.'s Motion For Partial Summary Judgment (Doc. 415) should be **DENIED**; (3) Plaintiffs' Motion for Partial Summary Judgment On Issue Related To Whether Humana Can Litigate The Underlying Validity of Individual Benefit Claims (Doc. 407) should be **DENIED**; and (4) Plaintiffs' Motion For Summary Judgment With Respect to Humana's Counterclaim (Doc. 449) should be **GRANTED in part** and **DENIED in part.**.

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IN CHAMBERS in Gainesville, Florida, on October 21, 2011.

s/Gary R. Jones
GARY R. JONES
United States Magistrate Judge

NOTICE TO THE PARTIES

Pursuant to Fed. R. Civ. P. 72(b)(2), a party may file specific, written objections to the proposed findings and recommendations within 14 days after being served with a copy of this report and recommendation. A party may respond to another party's

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objections within 14 days after being served with a copy thereof. Failure to file specific objections limits the scope of review of proposed factual findings and recommendations.

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EXHIBIT 8

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EXHIBIT 8

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July 3, 2003

RODOLFO SORONDO, JR.
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Honorable Federico A. Moreno
United States District Judge
99 N.E. 4 Street, Ste1061
Miami, Florida 33132

Re: Managed Care Litigation MDL No. 1334
Master File No. 00-1334-MDL-MORENO
<u>REPORT AND RECOMMENDATION</u>

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Dear Judge Moreno:

By letter dated June 19, 2003, defendants requested an order compelling plaintiffs to fully and promptly answer four interrogatories that defendants served on May 2, 2003. The interrogatories read as follows:

> 1. Identify each and every Claim that You contend a Defendant improperly downcoded, bundled, reduced, denied, delayed or otherwise improperly processed ("Disputed Claim").
>
> 2. For each Disputed Claim, state all facts in support of Your contention that the Defendant improperly processed the Claim, including but not limited to the amount of any alleged underpayment and/or interest You contend is owing as a result of the alleged improper processing.
>
> 3. Identify each Disputed Claim that You appealed, filed a grievance on, or otherwise communicated (orally or in writing, but excluding the more submission of a claim without further communication) any dispute, question, or disagreement regarding the processing of the Disputed Claim to the applicable Defendant,

including (a) whether such communication was made, (c) the individuals to whom such communication was made, (c) the persons employed, retained, or otherwise engaged by You who communicated the dispute or disagreement; and (d) the outcome of such grievance, appeal, or communication.

Plaintiffs do not contest that they must respond but insist that it is impossible to do so in many cases, and, virtually impossible in most. They argue that once they have received defendants' electronic data production it will be extremely easy to respond to these interrogatories and they request 30 days from the August 14, 2003, deadline for defendants' data production to comply.

Defendants further request that plaintiffs produce the following four categories of medical records:

1. Defendants request medical records *concerning* those claims that the provider plaintiffs contend were improperly denied, delayed or reduced by the defendants. This request incorporates the interrogatories discussed *supra* and seeks the medical records pertaining to each of those disputed claims.

2. Defendants request medical records concerning any claim in which a provider plaintiff *received payment* for services rendered to the same patient on the same date of service and described the services rendered to the patient with two or more CPT codes. In addition, defendants request medical records concerning any claim in which a provider plaintiff *received payment* for services rendered to a patient and described the services rendered to the patient with any of the following CPT codes: 99203, 99204, 99205, 99214, 99215, 99222, 99223, 99232, 99233, 99238, 99239, 99243, 99244, 99245, 99254, 99255, 99435, 97110 and 97530. These records relate, among other things, to obvious negative and affirmative defenses that the defendants are likely to raise in this case, such as a negative defense with respect to plaintiffs' RICO injury burden, and an affirmative defense of recoupment with respect to plan overpayments.

3. Defendants request medical records concerning any claims relied upon by plaintiffs' injury/damages expert(s) for purposes of rendering an opinion regarding the extent of any damages suffered by the provider plaintiffs and the members of the class. Defendants have informed the plaintiffs that, if their trial injury/damages expert(s) has not yet been identified or has not yet

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selected any claims for analysis, we would expect plaintiffs to supplement their production of medical records once such expert(s) or claims are identified.

4. Defendants requested medical records concerning the claims of absent class members who alleged in the Amended RICO Case Statement that defendants improperly denied, delayed or reduced payment on those claims. In connection with this request, defendants have asked the plaintiffs to confirm whether they will be willing to collect the requested medical records form the providers who made allegations in the Amended RICO Case Statement or whether it will be necessary to issue subpoenas to secure the relevant records.

Plaintiffs first argue that these medical records are irrelevant, and, even if relevant, production presents the same problems as responding to the interrogatories.

Defendants' suggestion that the medical records are irrelevant is untenable. The concept of relevance for discovery purposes is extremely elastic and the medical records described above are clearly relevant.[1]

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The true issue presented for resolution is the time frame for plaintiffs' responses to these valid discovery requests. Defendants argue that the difficulties of producing these materials is irrelevant, and that just as defendants have been compelled to produce massive amounts of materials by August 14, 2003, plaintiffs should likewise be compelled to respond by the same deadline. Moreover, they argue that production of these records in the middle or end of September unfairly curtails the time defendants will ultimately have to depose the physicians and other people who have knowledge of these records.

Plaintiffs, on the other hand, insist that production of these documents for the time period of the complaint is impossible or virtually impossible. They

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[1] See *Etienne v. Volverine Tube, Inc.*, 185 F.R.D. 653, 656 (D. Kan 1999) (quoting *Smith v. MCI Telecomm. Corp.*, 137 FR.D. 25, 27 (D. Kan. 1991) ("Relevancy is broadly construed, and a request for discovery should be considered relevant if 'there is any possibility that the information sought may be relevant to the subject matter to the action.'"); *Swoden v. Connaught Laf.*, 137 F.R.D. 336, 341 (D. Kan. 1991)("A request for discovery should ordinarily be allowed unless it is clear that the information sought can have no possible hearing on the subject matter of the action.").

observe that many of their physician clients have small practices and do not have sophisticated storage systems that allow for retrieval of the necessary information, and assure the court that production of the necessary materials can be achieved within 30 days of the August 14 data production.

The undersigned respectfully recommends that plaintiffs be allowed to respond to these requests by Monday, September 15, 2003. This recommendation, and this Court's order should it decide to accept it, should be without prejudice to revisit the issue in the event that software or other computer problems make it impossible to comply by the September 15th deadline.

Respectfully submitted,

HOLLAND & KNIGHT LLP

R. Sorondo, Jr.

RODOLFO SORONDO, JR.

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RS/cmc

cc: Harley Tropin, Esquire
Edward Soto, Esquire

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MIA1 #1236341 v1

APPENDIX Q
TAB 2

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UNITED STATES DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF FLORIDA
Miami Division

MDL No. 1334
Master File No. 00-1334-MD-MORENO

IN RE: MANAGED CARE LITIGATION

FILED by JSU D.C.
JUL 24 2003
CLARENCE MADDOX
CLERK U.S. DIST. CT.
S.D. OF FLA.

THIS DOCUMENT RELATES TO
PROVIDER TRACK CASES
/

ORDER ADOPTING IN PART SPECIAL MASTER'S DISCOVERY REPORTS AND RECOMMENDATIONS

THIS MATTER came before the Court upon three discovery Reports and Recommendations issued by Special Master Rodolfo Sorondo, Jr., Esq. on **July 3, 2003**. The Court held a telephonic hearing on **July 22, 2003**. The Court has reviewed the entire file and record. The Court has made a *de novo* review of the issues that the objections to the Special Master's Reports and Recommendations present, and being otherwise fully advised in the premises, it is

ADJUDGED that Special Master Rodolfo Sorondo, Jr., Esq.'s three discovery Reports and Recommendations are AFFIRMED and ADOPTED in part. Accordingly, it is

ADJUDGED as follows:

(1) Defendants' motion to compel production of documents by Barbara Cobuzzi d/b/a Cash Flow Solutions is GRANTED. Ms. Cobuzzi's undue burden and jurisdictional objections are OVERRULED, and she is hereby DIRECTED to comply with the subpoena forthwith in the manner outlined in the Special Master's Report and Recommendation.

(2) Defendants' motion to compel Plaintiffs to answer four interrogatories outlined in the Special Master's Report and Recommendation is GRANTED in part. Plaintiffs shall serve

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answers to these interrogatories by no later than **September 15, 2003**.

(3) Defendants' motion to compel Plaintiffs to produce four categories of medical records outlined in the Special Master's Report and Recommendation is GRANTED in part. Plaintiffs' relevancy objection is OVERRULED, and they shall respond to these document requests by no later than **September 15, 2003**.

(4) Defendant PacifiCare Health Systems, Inc.'s motion for a protective order is TAKEN UNDER ADVISEMENT. Any Defendant may file a pleading addressing Plaintiffs' request for "claims data" by no later than **August 4, 2003**. This pleading may include, *inter alia*, argument as to the burden of production, an explanation of the data already provided, a representative sample of the data sought by Plaintiffs, any alternative summary of data proposed by Defendants, and discussion of whether the "claims date" can be provided incrementally. Plaintiffs may file a response by no later than **August 11, 2003**. In light of the above, and unless otherwise ordered by the Court, Defendant PacifiCare Health Services, Inc. shall provide the "claims data" by no later than **October 15, 2003**. The deadline for the remaining Defendants remains the same as no motion or objection as to those Defendants is properly before the Court.

(5) Plaintiffs' motion to compel Defendants to identify which documents produced in response to Plaintiffs' **October 1, 2002**, request for production also satisfy Plaintiffs' **March 18, 2003**, request for production is DENIED.

DONE AND ORDERED in open court at the United States District Courthouse in Miami, Florida, on July 22, 2003, and signed this 24th day of July, 2003.

FEDERICO A. MORENO
UNITED STATES DISTRICT JUDGE

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THE **JULY 1, 2003** SERVICE LIST

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EXHIBIT 9

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Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation, Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: 2:19-cv-00832-JAD-VCF **FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.'S OBJECTIONS AND ANSWERS TO DEFENDANTS' FIRST SET OF INTERROGATORIES**

Fremont Emergency Services (Mandavia), Ltd. ("Fremont") hereby responds to defendants United HealthCare Insurance Company ("UHCIC"), United HealthCare Services, Inc. ("UHS"), UMR, Inc. ("UMR"), Oxford Health Plans, Inc. ("Oxford"), Sierra Health and Life Insurance Company, Inc. ("SHL"), Sierra Health-Care Options, Inc. ("SHO") and Health Plan of Nevada, Inc. ("HPN") (collectively "UnitedHealthcare" or "Defendants")'s First Set of Interrogatories, served to Fremont's counsel pursuant to FRCP 33.

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INTERROGATORIES

Interrogatory No. 1:

Identify and describe all of the Healthcare Claims that Fremont contends it is asserting in this Action. Your description should include, at a minimum, the following information: (a) the patient's name, (b) the patient's date of birth, (c) the patient's social security number, (d) the patient/insured's I.D. number, (e) the patient's account number, (f) the name of the medical provider, (g) the date the medical service was provided, (h) the amount billed by Fremont for the medical service, (i) the amount Defendants paid to Fremont, (j) the additional amount of reimbursement Fremont is demanding from Defendants, and (k) a brief description of the nature of the illness or injury that was being treated. This information may be provided in the form of a list, chart, spreadsheet and/or table if that is the most convenient/efficient way to provide the requested information.

Answer to Interrogatory No. 1:

Objection. This Interrogatory seeks information that is already in UnitedHealthcare's possession, is not proportional to the needs of this case in that it seeks information not necessary to any element of proof of any claim or defense and exceeds any reasonable request related to identification of the claims at issue (e.g. the patient/insured's I.D. number and the patient's account number, the name of the medical provider and a brief description of the nature of the illness or injury). In addition, this Interrogatory is not reasonably calculated to lead to the discovery of admissible evidence because certain subparts have no relevance or bearing on the claims at issue in the litigation (e.g. the name of the medical provider or a brief description of the nature of the illness or injury that was being treated) and is compound. Further, Fremont objects to the request to provide a brief description of the nature of the illness or injury that was being treated because that information can be generally gleaned from the E/M Code, the Member's medical records, to the extent they are in UnitedHealthcare's possession, and documents that are within the possession of UnitedHealthcare.

Subject to and without waiving the foregoing objections, Fremont will produce a spreadsheet identifying the claims at issue in the litigation. Fremont further submits that the

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claims at issue continue to accrue and the list being produced is only for claims in which services were provided on or before April 30, 2019.

Interrogatory No. 2:

Paragraph 36 of the Complaint states: "At all material times, the UH Parties were aware that Fremont was entitled to and expected to be paid at rates in accordance with the standards established by Nevada law." Identify all Nevada statutes and regulations that establish the rate of payment standards referenced in this paragraph.

Answer to Interrogatory No. 2:

Objection. This request improperly limits the allegations in Paragraph 36 of the Complaint (Fremont's breach of implied-in-fact contract claim) to statutory and regulatory authority as the term "Nevada law" encompasses common law and equitable remedies. Fremont further objects on the basis that this Interrogatory calls for a legal conclusion. Subject to the foregoing objections, Fremont responds, that in addition to the existence of a common law implied-in-fact contract, and other common law bases which support Fremont's claims, the following NRS and NAC provisions support its allegation: NRS 679B.152; NRS 683A.0879; NRS 686A.310; NRS 689A.0495; NRS 689A.410; NRS 689B.045; NRS 689B.255; NRS 689C.485; NRS 695C.179; NRS 695C.185; NAC 686A.270; NAC 686A.290; NAC 686A.306; NAC 686A.675; NRS 695G.170.

Interrogatory No. 3:

Paragraph 46 of the Complaint refers to "the rates required by Nevada law." Identify all Nevada statutes and regulations that this paragraphs is referring to.

Answer to Interrogatory No. 3:

See Objections and Response to Interrogatory No. 2.

Interrogatory No. 4:

To the extent Fremont contends that any of the Defendants orally promised/committed to reimburse Fremont at a particular rate for the Healthcare Claims that Fremont contends it is asserting in this Action, please identify the individual who made the oral promise/commitment, the approximate date the oral promise/commitment occurred, which Fremont employee the oral

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promise/commitment was made to, and describe in detail the nature of the oral promise/commitment.

Answer to Interrogatory No. 4:

Objection. This request is compound and is vague and ambiguous with respect to the phrase "oral promise/commitment." Subject to and without waiving the foregoing objections, UnitedHealthcare publicly commits that it pays for out-of-network services at the lower of 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. *See* FESM000335-341. UnitedHealthcare further represents that "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." Despite these commitments, "UnitedHealthcare uses a service called Data iSight to review select out-of-network claims and recommend a reduced payment amount for out-of-network covered services. When UnitedHealthcare reduces payment of Fremont's billed charges, it states that the "charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement." UnitedHealthcare seemingly admits that there if there is not a contracted fee arrangement then it is bound by a legislated fee arrangement. Upon entry of a confidentiality agreement and protective order, Fremont will produce a sample Explanation of Benefits consistent with the foregoing.

Interrogatory No. 5:

Identify and describe the actions taken by Defendants that led to the creation of the implied-in-fact contract alleged by Fremont in the Complaint.

Answer to Interrogatory No. 5:

Objection. To the extent this Interrogatory calls for a legal conclusion, it is improper. Subject to and without waiving the foregoing objection, Fremont responds as follows: Fremont is a professional practice group of emergency medicine providers that staffs certain emergency department services in Clark County, Nevada, including the emergency departments at Sunrise Hospital; Mountain View Hospital; Southern Hills Hospital; Dignity Health, St. Rose Dominican

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Hospital - Rose De Lima Campus; St. Rose Dominican Hospital - Siena Campus; Dignity Health, St. Rose Dominican Hospital - San Martin Campus and ER at the Lakes. UnitedHealthcare and its defendant affiliates are health care insurance companies and/or administrators that provide coverage to their Members. Federal and state laws require Fremont to treat individuals who present for treatment in emergency departments that it staffs, regardless of that person's ability to pay. *See e.g.* Emergency Medical Treatment & Labor Act ("EMTALA"), 42 U.S.C. § 1395dd; NRS 439B.410. UnitedHealthcare has opted to provide and/or administer health insurance coverage to certain individuals enrolled in its health plans in Nevada. UnitedHealthcare is required legally and contractually to cover and pay for emergency department services provided to its Members. Because Fremont has already provided emergency medicine services to UnitedHealthcare's Members and UnitedHealthcare is obligated to pay for those services as a Nevada health insurer and managed care organization, it is implicit and expected that UnitedHealthcare will pay Fremont for the billed charges. UnitedHealthcare previously paid Fremont for emergency medicine services administered to UnitedHealthcare's Members on an out-of-network basis at rates acceptable to Fremont. However, that changed when UnitedHealthcare started paying lower reimbursement rates not reflective of the billed charges, or a usual and customary rate or for the reasonable value of the services provided. In the simplest of terms: Fremont is not obligated to provide emergency services to UnitedHealthcare Members at rates that are not usual and customary or reflective of the reasonable value of the emergency medicine services provided. For purposes of this litigation, Fremont seeks additional payment from UnitedHealthcare in connection with claims that UnitedHealthcare paid at a rate lower than 75% of billed charges.

<u>Interrogatory No. 6</u>:

Identify all individuals who are or have been involved in "business discussions regarding the potential for Fremont to become a participating provider" as referenced in paragraph 26 of the Complaint. The information should include each individual's full name, address, phone number and what entity they work for or are associated with (i.e. Fremont, Defendants, etc.).

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Answer to Interrogatory No. 6:

Kent Bristow, Senior Vice President, Revenue Management for TeamHealth Holdings, Inc., 265 Brookview Centre Way Ste. 400, Knoxville, Tennessee. Fremont is part of the TeamHealth organization. **Mr. Bristow may only be contacted through Fremont's counsel of record.**

Jennifer Shrader, Vice President of Managed Care Contracting for TeamHealth Holdings, Inc., 265 Brookview Centre Way Ste. 400, Knoxville, Tennessee. **Ms. Shrader may only be contacted through Fremont's counsel of record.**

Rena Harris, Senior Contracts Manager, for TeamHealth Holdings, Inc., 8511 Fallbrook Ave, Suite 120, West Hills, CA 91304. Ms. Harris was involved with negotiations with HPN, SHO and SHL on behalf of TeamHealth Holdings, Inc. Ms. Harris may only be contacted through Fremont's counsel of record.

Mark Kline was formerly employed by TeamHealth Holdings, Inc. as a Vice President, Managed Care. Mr. Kline's email address is: mgklinetexas@sbcglobal.net. **Mr. Kline may only be contacted through Fremont's counsel of record.**

Dan Schumacher, the President and Chief Operating Officer of UnitedHealthcare and part of the Office of the Chief Executive of UnitedHealth Group, Inc. Defendants have Mr. Schumacher's contact information.

Angie Nierman, a Vice President of Networks at UnitedHealth Group, Inc. Defendants have Ms. Nierman's contact information.

Dan Rosenthal, President of UnitedHealth Networks, Inc. Defendants have Mr. Rosenthal's contact information.

John Haben, Vice President of UnitedHealth Networks, Inc. Defendants have Mr. Haben's contact information.

Jacy Jefferson, Associate Director, Network Development & Contracts for Health Plan of Nevada/Sierra Health & Life, UnitedHealthcare – Nevada. Defendants have Mr. Jefferson's contact information.

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Greg Dosedel, Vice President of National Ancillary Contracting & Strategy at UnitedHealthcare Services, Inc. Defendants have Mr. Dosedel's contact information.

DATED this 29th day of July, 2019.

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By: /s/ *Kristen T. Gallagher*

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 29th day of July, 2019, I caused a true and correct copy of the foregoing **FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.'S OBJECTIONS AND ANSWERS TO DEFENDANTS' FIRST SET OF INTERROGATORIES** to be served via U.S. Mail, postage prepaid upon the following:

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/s/ *Karen Surowiec*
An employee of McDonald Carano LLP

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Attorneys for Defendants

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs, vs. UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: A-19-792978-B Dept. No.: 27 **DEFENDANTS' ANSWER TO PLAINTIFFS' FIRST AMENDED COMPLAINT**

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270. Answering paragraph 270 of the First Amended Complaint, United denies the allegations contained in this paragraph.

271. Answering paragraph 271 of the First Amended Complaint, United admits that it processes and, where appropriate, pays claims for services provided to participants in health plans it insures or administers. United denies the remaining allegations in Paragraph 271.

272. Answering paragraph 272 of the First Amended Complaint, United denies the allegations contained in this paragraph.

273. Answering paragraph 273 of the First Amended Complaint, United denies the allegations contained in this paragraph.

274. Responding to Plaintiff's **"REQUEST FOR RELIEF"**, including the "WHEREFORE" statement and all subparts thereto, Defendants deny that they are liable to Plaintiffs in any fashion or in any amount.

AFFIRMATIVE DEFENSES

Defendants have not yet completed their investigation in this matter. Notably, Plaintiffs have failed to adequately plead the specific claims at issue, including as to individual members, the health care coverage they possessed on the dates of service at issue, the terms of their various health care plans, the specific services rendered, and the payment and processing history to date. Without such basic identification, United is unable to adequately respond to the asserted claims. United reserves all rights to alter or amend its responsive pleading and affirmative defenses at such time as Plaintiffs provide the information necessary to identify the claims at issue.

Without assuming the burden of proof where it otherwise rests with Plaintiffs, United asserts the following defenses as may prove applicable after discovery or trial:

FIRST AFFIRMATIVE DEFENSE

For the reasons detailed in United's Motion to Dismiss, Plaintiffs' First Amended Complaint fails to state a claim upon which relief can be granted.

SECOND AFFIRMATIVE DEFENSE

To the extent to be determined through review of subsequently identified claims, some or all of the claims may be preempted by the Employee Retirement Income Security Act of 1974

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("ERISA") to the extent the members in question obtain their health care coverage through employer-based health plans. Such claims relate to payments under plans governed by ERISA, and all such claims are both conflict and completely preempted by ERISA for the reasons detailed in United's Motion to Dismiss.

THIRD AFFIRMATIVE DEFENSE

This Court does not have subject matter jurisdiction over the claims asserted against United. Plaintiffs' claims arise under ERISA and therefore implicate federal question jurisdiction.

FOURTH AFFIRMATIVE DEFENSE

The claims asserted are barred by the absence of an applicable duty running from United to Plaintiffs. Among other reasons, as out-of-network providers, Plaintiffs have chosen not to enter into any contractual relationship or rate agreement with United, nor has any duty arisen by operation of Nevada law for the reasons detailed in United's Motion to Dismiss.

FIFTH AFFIRMATIVE DEFENSE

The terms and conditions of the applicable health plans are incorporated by reference, as if fully set forth herein, and stand as a bar to some or all of the relief requested. United reserves all rights with respect to asserting this defense once Plaintiffs have adequately identified the specific benefit claims that they contend were underpaid for purposes of the lawsuit, and the specific plans at issue

SIXTH AFFIRMATIVE DEFENSE

Some or all of Plaintiffs' billed charges are excessive under the applicable standards, and/or Plaintiffs have failed to identify any basis for entitlement to demand receipt of any fixed percentage of billed charges.

SEVENTH AFFIRMATIVE DEFENSE

Some or all of the claims asserted are untimely, and/or subject to statute of limitations or contractual limitations periods. United reserves all rights with respect to asserting this defense once Plaintiffs have adequately identified the specific benefit claims that they contend were underpaid for purposes of the lawsuit, and the specific plans at issue.

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EIGHTH AFFIRMATIVE DEFENSE

Some or all of the claims asserted are subject to rates set by Plaintiffs' participation in MultiPlan, Inc. United reserves all rights with respect to asserting this defense once Plaintiffs have adequately identified the specific benefit claims that they contend were underpaid for purposes of the lawsuit.

NINTH AFFIRMATIVE DEFENSE

To the extent that Plaintiffs have any right to receive plan benefits, that right is subject to basic preconditions and prerequisites that have not been established, such as that the patients are members of United on the date of service, that the coordination of benefits has been applied, that the services were medically necessary, that an emergency medical condition was present, that Plaintiffs timely submitted correctly coded claims and supplied any requested documentation, and/or that any necessary authorizations were obtained, and United reserves all rights with respect to asserting any and all such defenses once Plaintiffs have adequately identified the specific claims that they contend were underpaid for purposes of the lawsuit.

TENTH AFFIRMATIVE DEFENSE

Plaintiffs lack standing to pursue claims against United.

ELEVENTH AFFIRMATIVE DEFENSE

Upon information and belief, and to the extent to be determined through subsequent claims identification by Plaintiffs, some or all of the Defendants did not function as an insurer or issuer of the unspecified health plan coverage alleged to be at issue, and Plaintiffs therefore lack standing as to any such Defendant.

TWELFTH AFFIRMATIVE DEFENSE

Plaintiffs failed to timely correct known defects with respect to some or all of the claims asserted. United reserves all rights with respect to asserting this defense once Plaintiffs have adequately identified the specific benefit claims that they contend were underpaid for purposes of the lawsuit, and the specific plans at issue.

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THIRTEENTH AFFIRMATIVE DEFENSE

Plaintiffs' claims are barred, in whole or in part, to the extent that they seek to unjustly enrich Plaintiffs by allowing them to retain funds in excess of any amounts due for covered services under plans insured or administered by United. United reserves all rights with respect to asserting this defense once Plaintiffs have adequately identified the specific benefit claims that they contend were underpaid for purposes of the lawsuit, and the specific plans at issue.

FOURTEENTH AFFIRMATIVE DEFENSE

Plaintiffs' claims are barred, in whole or in part, to the extent they have not suffered any damages.

FIFTEENTH AFFIRMATIVE DEFENSE

Plaintiffs' claims are barred, in whole or in part, to the extent any alleged liability to or damages suffered by Plaintiffs were not proximately caused by United, or by the conduct alleged.

SIXTEENTH AFFIRMATIVE DEFENSE

Plaintiffs' claims are barred in whole or in part by the failure to exhaust mandatory administrative and/or contractual remedies. United reserves all rights with respect to asserting this defense once Plaintiffs have adequately identified the specific benefit claims that they contend were underpaid for purposes of the lawsuit, and the specific plans at issue.

SEVENTEENTH AFFIRMATIVE DEFENSE

Plaintiffs' claims are barred in whole or in part to the extent Plaintiffs are pursuing claims that they do not possess the legal right to pursue, including, but not limited to, benefit claims with respect to which they did not obtain effective assignments from their patients.

EIGHTEENTH AFFIRMATIVE DEFENSE

Plaintiffs' claims are barred, in whole or in part, to the extent that Plaintiffs have not mitigated their damages by seeking reimbursement from other sources, including, but not limited to, other health plans, programs, or entities that may have had an obligation to pay.

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NINETEENTH AFFIRMATIVE DEFENSE

Plaintiffs' claims are barred in whole or in part, by the equitable doctrines of waiver, estoppel, laches, and/or unclean hands. United reserves all rights with respect to asserting this defense once Plaintiffs have adequately identified the specific benefit claims that they contend were underpaid for purposes of the lawsuit, and the specific plans at issue.

TWENTIETH AFFIRMATIVE DEFENSE

Plaintiffs' claims are barred to the extent the monetary relief sought under theories of restitution, disgorgement, constructive trust and/or any other theory is not equitable, and thus not available under those theories.

TWENTY-FIRST AFFIRMATIVE DEFENSE

Plaintiffs' claims are barred, in whole or in part, to the extent Plaintiffs failed to sue the appropriate entity. United reserves all rights with respect to asserting this defense once Plaintiffs have adequately identified the specific benefit claims that they contend were underpaid for purposes of the lawsuit, and the specific plans at issue.

TWENTY-SECOND AFFIRMATIVE DEFENSE

Plaintiffs' claims are barred, in whole or in part, by the doctrines of accord and satisfaction and/or release. United reserves all rights with respect to asserting this defense once Plaintiffs have adequately identified the specific benefit claims that they contend were underpaid for purposes of the lawsuit, and the specific plans at issue.

TWENTY-THIRD AFFIRMATIVE DEFENSE

Plaintiffs' claims are barred, in whole or in part, by the doctrines of res judicata and/or collateral estoppel. United reserves all rights with respect to asserting this defense once Plaintiffs have adequately identified the specific benefit claims that they contend were underpaid for purposes of the lawsuit, and the specific plans at issue.

TWENTY-FOURTH AFFIRMATIVE DEFENSE

Plaintiffs' claims are subject to setoff and/or recoupment with respect to claims for which United made payment on the basis of current procedural terminology ("CPT") or other billing codes included in Plaintiffs' submissions that Plaintiffs' clinical records of their patients' care

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reveal to have been improperly submitted, either because Plaintiffs' clinical records do not support submission of the codes at all, or because Plaintiffs' clinical records establish that different codes should have been submitted.

TWENTY-FIFTH AFFIRMATIVE DEFENSE

Plaintiffs' claims are subject to setoff and/or recoupment with respect to claims for which United made payment on the basis of Plaintiffs' billed charges and those billed charges exceeded the billed charges submitted to other payors, where Plaintiffs never intended to collect such charges from any other payors, or where the charges were otherwise in error.

TWENTY-SIXTH AFFIRMATIVE DEFENSE

Plaintiffs are not entitled to relief because they have received all payments due, if any, for the covered services they provided in accordance with the terms of their patients' health plans.

TWENTY-SEVENTH AFFIRMATIVE DEFENSE

Plaintiffs' claim for punitive damages cannot be sustained because an award of punitive damages that is subject to no predetermined limit, such as a maximum multiple of compensatory damages or a maximum amount of punitive damages that may be imposed, would: (1) violate Defendants' Due Process rights guaranteed by the Fifth and Fourteenth Amendments to the United States Constitution; (2) violate Defendants' rights not to be subjected to an excessive award; and (3) be improper under the Constitution, common law and public policies of Nevada.

TWENTY-EIGHTH AFFIRMATIVE DEFENSE

It has been necessary for Defendants to employ the services of an attorney to defend the action and a reasonable sum should be allowed Defendants for attorney's fees and all incurred costs of the suit.

TWENTY-NINTH AFFIRMATIVE DEFENSE

Pursuant to NRCP 11, as amended, all possible affirmative defenses may not have been alleged herein insofar as facts were not available after reasonable inquiry upon the filing of this Answer, and therefore, Defendants reserve the right to amend their Answer to Plaintiffs' First Amended Complaint to allege additional affirmative defenses if subsequent investigation warrants.

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WHEREFORE, having fully responded to the allegations of the First Amended Complaint, United prays:

1. That Plaintiffs' First Amended Complaint be dismissed with prejudice and that Plaintiffs take nothing thereby;

2. That Plaintiffs take nothing by their First Amended Complaint;

3. That Defendants be discharged from this action without liability;

4. That the Court award to Defendants all of their costs and attorneys' fees in defending this action; and

5. That the Court award to Defendants such other and further relief as the Court deems just and proper.

Dated this 8th day of July, 2020.

/s/ Brittany M. Llewellyn

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Sierra Health and Life Insurance Co., Inc.,
Sierra Health-Care Options, Inc., and
Health Plan of Nevada, Inc.

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CERTIFICATE OF SERVICE

I hereby certify that on the 8th day of July, 2020, a true and correct copy of the foregoing **DEFENDANTS' ANSWER TO PLAINTIFFS' FIRST AMENDED COMPLAINT** was electronically filed/served on counsel through the Court's electronic service system pursuant to Administrative Order 14-2 and N.E.F.C.R. 9, via the electronic mail addresses noted below, unless service by another method is stated or noted:

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Attorneys for Plaintiffs

/s/ Kelly L. Pierce
An employee of WEINBERG, WHEELER, HUDGINS GUNN & DIAL, LLC

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EXHIBIT 11

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EXHIBIT 11

IN THE CIRCUIT COURT OF THE NINTH JUDICIAL CIRCUIT IN AND FOR ORANGE COUNTY, FLORIDA

CASE NO. 2008-CA-011145 (Div. 43)

Complex Business Litigation Section

ADVENTIST HEALTH SYSTEM/ SUNBELT, INC., a Florida not-for-profit corporation, a/k/a FLORIDA HOSPITAL,

Plaintiff,

vs.

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC., a Florida corporation, and HEALTH OPTIONS, INC., a Florida corporation,

Defendants.

_____/

ORDER ON DEFENDANTS' MOTION TO COMPEL PRODUCTION OF DOCUMENTS AND ANSWERS TO INTERROGATORIES

THIS CAUSE came before the Court upon Defendants Blue Cross and Blue Shield of Florida, Inc. and Health Options, Inc.'s Motion to Compel Production of Documents and Answers to Interrogatories.

THE COURT has considered the Motion to Compel, the pertinent parts of the record, and heard oral argument of counsel as well as received certain stipulations of the parties on March 10, 2010, and being otherwise fully advised in the premises, it is

eFiled in the Office of Clerk of Court, Orange County Florida 2010 Jun 10 03:29 PM Lydia Gardner

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ADJUDGED that the Motion to Compel is GRANTED in part and DENIED in part as set forth below. To the extent that this Order denies the Motion to Compel, it does so *without prejudice*. Within thirty (30) days of the date of this Order, Plaintiff Adventist Health System/Sunbelt, Inc. a/k/a Florida Hospital ("Florida Hospital") shall produce the documents and information identified below responsive to Defendants' First Request for Production of Documents ("Document Requests") and First Set of Interrogatories ("Interrogatories"). To the extent that Florida Hospital withholds any documents or information on the basis of privilege or work product protection, Florida Hospital shall provide a privilege log, with the exception of privileged communications between Zumpano Patricios and Winker and Florida Hospital post-dating the commencement of this case. This Order also is without prejudice to Defendants challenging the sufficiency of Florida Hospital's production of documents, provision of additional information, and/or amended responses to the Document Requests and Interrogatories.

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1. Document Request No. 1 and Interrogatory No. 3. Florida Hospital shall produce all documents within its possession, custody or control responsive to Document Request No. 1, including, without limitation, claim forms, explanation of benefits forms or remittance advices, correspondence with Blue Cross and Blue Shield of Florida, Inc., Health Options, Inc. or Florida Hospital's patients

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concerning these claims, and any documents concerning collection activities undertaken by Florida Hospital with respect to these claims. Florida Hospital also shall provide an accounting of the amounts that Florida Hospital seeks in this case, including the amounts billed, the amounts received from Blue Cross and Blue Shield of Florida, Inc. or Health Options, Inc., and any amounts received from (and the identity of) any other sources.

2. Document Request No. 3 and Interrogatory Nos. 2, 4. Florida Hospital shall produce its chargemasters from 2003 to the present, as well as the "PARRA studies" that form the basis for its chargemasters. Florida Hospital also shall identify all persons responsible for setting or determining the amount billed by Florida Hospital for the types of services for which Florida Hospital seeks relief in this case from 2003 to the present.

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3. Document Request Nos. 4, 6, 7 & Interrogatory No. 6. Florida Hospital shall produce documents sufficient to show the amounts accepted by Florida Hospital for the types of services for which it seeks relief in this case from 2003 to the present, itemized by payor, with the exception of amounts accepted from Medicare and Medicaid for which the Motion to Compel is denied *without prejudice*. Florida Hospital may redact the identity of payors with whom it has

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confidentiality agreements. Florida Hospital also shall produce all documents within its possession, custody or control responsive to Document Request No. 7.

4. Document Request No. 5. Florida Hospital shall produce all responsive documents within its possession, custody or control. If Florida Hospital does not have any responsive documents within its possession, custody or control, Florida Hospital shall serve an amended response to the Document Requests stating that it does not have any responsive documents within its possession, custody or control.

5. Document Request No. 11. Florida Hospital shall produce the entire medical record for each patient for whom Florida Hospital provided inpatient services for which it seeks relief in this case.

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6. Document Request Nos. 12-16. Florida Hospital shall produce all responsive documents within its possession, custody or control concerning (i) evaluation of whether a patient who presents to the emergency room has an emergency medical condition, (ii) relief or elimination of that emergency medical condition, and (iii) subsequent inpatient admission, transfer or discharge.

7. Document Request No. 17. Florida Hospital shall produce all responsive internal and external communications within its possession, custody and control.

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8. Document Request Nos. 18, 24. Florida Hospital shall produce all responsive documents within its possession, custody or control, including, without limitation, all documents provided to Mr. Lynck, all documents relied upon by Mr. Lynck, and any notes or draft reports prepared by Mr. Lynck.

9. Interrogatory Nos. 5, 7, 8. Florida Hospital shall serve amended responses to these interrogatories, specifically identifying each document upon which it relies in answering each of these interrogatories, and certifying that those documents are the sole bases for the allegations identified in these interrogatories as of the time of service of the amended responses.

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DONE AND ORDERED in Chambers, in Orange County, Florida, this 9 day of ~~March~~ June, 2010.

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FREDERICK J. LAUTEN
CIRCUIT COURT JUDGE

cc: Leon N. Patricios, Esq., 312 Minorca Avenue, Coral Gables, Florida 33134
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MIA 357914-4.022370.0043

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DISTRICT COURT
CLARK COUNTY, NEVADA

Fremont Emergency Services (Mandavia) Ltd, Plaintiff(s) vs. United Healthcare Insurance Company, Defendant(s)	CASE NO: A-19-792978-B DEPT. NO. Department 27

AUTOMATED CERTIFICATE OF SERVICE

This automated certificate of service was generated by the Eighth Judicial District Court. The foregoing Motion was served via the court's electronic eFile system to all recipients registered for e-Service on the above entitled case as listed below:

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Attorneys for Plaintiffs

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs, vs. UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: A-19-792978-B Dept. No.: XXVII **NOTICE OF ENTRY OF ORDER GRANTING, IN PART PLAINTIFFS' MOTION TO COMPEL DEFENDANTS' PRODUCTION OF CLAIMS FILE FOR AT-ISSUE CLAIMS, OR, IN THE ALTERNATIVE, MOTION IN LIMINE**

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PLEASE TAKE NOTICE that an Order Granting, In Part Plaintiffs' Motion To Compel Defendants' Production Of Claims File For At-Issue Claims, Or, In The Alternative, Motion In Limine was entered on September 28, 2020, a copy of which is attached hereto.

DATED this 28th day of September, 2020.

McDONALD CARANO LLP

By: */s/ Kristen Gallagher*

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 28th day of September, 2020, I caused a true and correct copy of the foregoing **NOTICE OF ENTRY OF ORDER GRANTING, IN PART PLAINTIFFS' MOTION TO COMPEL DEFENDANTS' PRODUCTION OF CLAIMS FILE FOR AT-ISSUE CLAIMS, OR, IN THE ALTERNATIVE, MOTION IN LIMINE** to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

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/s/ Beau Nelson
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This matter came before the Court on September 9, 2020 on plaintiffs Fremont Emergency Services (Mandavia), Ltd. ("Fremont"); Team Physicians of Nevada-Mandavia, P.C.

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("Team Physicians"); Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine's ("Ruby Crest" and collectively the "Health Care Providers") Motion to Compel Defendants' Production of Claims File for At-Issue Claims Or, In the Alternative, Motion in Limine on Order Shortening Time (the "Motion"). Pat Lundvall and Amanda M. Perach, McDonald Carano LLP, appeared on behalf of the Health Care Providers. Lee Roberts and Colby L. Balkenbush, Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC, appeared on behalf of defendants UnitedHealth Group, Inc.; UnitedHealthcare Insurance Company; United HealthCare Services, Inc.; UMR, Inc.; Oxford Health Plans, Inc.; Sierra Health and Life Insurance Co., Inc.; Sierra Health-Care Options, Inc.; and Health Plan of Nevada, Inc.'s (collectively, "United").

The Court, having considered the Motion, United's opposition, and the argument of counsel at the hearing on this matter, finds and orders as follows:

1. The Health Care Providers propounded their First Set of Interrogatories ("Interrogatories") and First Set of Requests for Production of Documents ("RFPs") on United on or around December 9, 2019.

2. In response to 19 RFPs**,** Resp. to RFP Nos. 3-7, 11-13, 15-20, 24, 37, 39-40, 42 (collectively, the "At-Issue RFPs"), United repeats the following objection with variation to acknowledge the request at issue (in bold):

> Fremont has asserted 15,210 CLAIMS where it alleges that Defendants did not reimburse Fremont for the full amount billed. **To produce the documents and communications related to any decision to reduce payment on a CLAIM**, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as Exhibit 1, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.
>
> Fremont has asserted 15,210 claims where it alleges that Defendants did not reimburse Fremont for the full amount billed. **To produce the documents and communications that relate to the methodology used to calculate the amount of reimbursement paid on Fremont's claims**, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual claims, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as Exhibit 1 to, this would be unduly

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> burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

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~~3. With respect to 5 Interrogatories, Answers to Interrog. Nos. 1, 5, 7, 8, 12 (collectively, the "At-Issue Interrogatories"), United repeats the same objection with the same variation to account for the question:~~

> Assuming those are the claims Fremont intended to refer to, Defendants object to this Interrogatory on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 CLAIMS where it alleges that Defendants did not reimburse Fremont for the full ~~amount billed. To determine how the amount of reimbursement for~~ each CLAIM was determined, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS and analyze it. As explained more fully in the burden declaration attached as Exhibit 1, this would be unduly burdensome and not proportional to the needs of the case as Defendants believe it will take 2 hours to pull each individual administrative record for a total of 30,420 hours of employee labor.

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4. Each of these objections is based on United's assertion that it is unduly burdensome to retrieve and produce what United refers to as the "administrative record."

5. On February 10, 2020, counsel for the Health Care Providers offered to reduce United's burden of producing certain Explanation of Benefits forms ("EOBs") and Providers Remittance Advice forms ("PRAs") by matching data contained in the Health Care Providers' at-issue claims spreadsheets:

> In advance of Wednesday's hearing, below is a discovery proposal that would result in an expedited ability for the parties to agree on the health care claims data and would eliminate or greatly reduce the need for United to collect and produce provider remittance forms/provider EOBs except for where the parties identify a discrepancy in the billed amount or allowed amounts or as specified below. Similarly, it would eliminate or greatly reduce the need for Fremont to collect and produce HCFA forms and related billing documents. Please review and let me know in advance of Wednesday's hearing whether United will agree to the following:
>
> The Health Care Providers have already produced a spreadsheet that includes member name and Defendants' claim no. (to the extent available in Health Care Providers' automated system), in addition to other fields:
>
> - Within 14 days, United provides matched spreadsheets and identifies any discrepancy in billed or allowed amounts fields;
> - Within 7 days thereafter, for claims upon which the billed and allowed data match, parties stipulate that there is no need for further production of EOBs and provider remittances for evidentiary purposes related to establishing the existence of the claim, services

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provided, amount billed by Health Care Providers and amount allowed by United.

- Approximately every quarter, this process will take place again with any new claims included in the Litigation Claims Spreadsheet that accrued after the previous spreadsheet was submitted.

United produces all EOBs/provider remittances for all Data iSight processed NV claims submitted by the Health Care Providers; and

United and the Health Care Providers respectively agree to provide a market file, i.e. a spreadsheet of payments from other payers (Health Care Providers) or a spreadsheet of payments to other providers (United) in the market which de-identifies the specific payer or provider, as applicable (for the time period 2016-Present). The parties agree to meet and confer promptly to agree on specified fields.

6. Counsel for United and the Health Care Providers engaged in meet and confers on these objections on June 9, 15 and 23 (addressing RFP Nos. 11, 12, 13, 21, 27, 37 and 44) and July 20, 21 and August 3, 2020 (addressing RFP Nos. 3-7, 11-13, 15-20, 24, 37, 39-40, 42 and Interrog. Nos. 1, 5, 7, 8 and 12)

7. United representative Sandra Way ("Way") provided a declaration (the "Way Declaration") setting forth the contention that it would take four full-time United representatives working for three years to pull records for the at-issue claims in this litigation. The Way Declaration does not state she has tried to review or retrieve any information in connection with this litigation.

8. During meet and confer efforts, United's counsel stated that the only responsive documents that existed with respect to the At-Issue RFPs appeared in the "administrative record" and that it was standing on its undue burden objection.

9. Thereafter, the Health Care Providers filed the subject Motion.

10. The Health Care Providers have disclosed spreadsheets which list each of the at-issue claims (the "At-Issue Claims") in FESM00344 and intend to supplement these spreadsheets on a regular basis (collectively the "Claims Spreadsheets").

11. In opposition to the Motion, United states that the documents relating to the At-Issue Claims that would be responsive to the At-Issue RFPs consist of the "administrative record" for each claim and that the "administrative record" consists of five categories of documents:

a. Member Explanations of Benefits ("EOBs");

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b. Provider EOBs and/or Provider Remittance Advices ("PRAs");

c. Appeals documents;

d. Any other documents comprising the administrative record, such as correspondence or clinical records submitted by the provider with its claim for reimbursement;

e. The plan documents in effect at the time of service.

(collectively, the "Administrative Record")

12. The party from whom discovery is sought, must show that the information is not reasonably accessible because of undue burden or cost. NRCP 26(b)(2)(B). "[T]he fact that discovery may involve some inconvenience or expenses is not sufficient, standing alone, to avoid the discovery process." *Martinez v. James River Ins. Co.,* No. 2:19-cv-01646-RFB-NJK, 2020 WL 1975371, at *1 (D. Nev. Apr. 24, 2020).

13. The Way Declaration does not assert that claim information is not reasonably accessible because of undue burden, nor does she assert any particular cost associated with retrieving and producing the information.

14. As a result, the Way Declaration does not meet the considerations under NRCP 26(b)(2)(B).

15. Even if United could make that showing, the Court "may nonetheless order discovery from such sources if the requesting party shows good cause, considering the limitations of Rule 26(b)(2)(C)." NRCP 26(b)(2)(B).

16. There is no basis for the Court to limit the claim-file discovery under NRCP 26(b)(2)(C) because (1) the discovery sought is not unreasonably cumulative or duplicative, and cannot be obtained from a source other than United, much less from another source that is more convenient, less burdensome, or less expensive; (2) the Health Care Providers have not had ample opportunity to obtain the information by discovery in the action; and (3) the proposed discovery is not outside the scope permitted by Rule 26(b)(1).

17. The Court has considered United's argument that the Motion should be denied based on the Doctrine of Unclean Hands. The Court finds that that argument has no merit.

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18. The Court has also considered United's argument that the method of production of the Administrative Records would not be proportional to the needs of the case. United's proposal to employ statistical sampling methodology, require the parties to employ experts to attempt to match each party's claims data, and/or only require the parties to produce documents related to a smaller set of the at-issue claims does not sufficiently address the discovery needed for the Health Care Providers to prosecute this case. ~~The Court further finds that the discovery sought in the Motion is proportional to the needs of this case considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information,~~ the ~~parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit.~~ NLA

Accordingly, good cause appearing, therefor,

ORDER

IT IS HEREBY ORDERED that the Health Care Providers' Motion to Compel Defendants' Production of Claims File for At-Issue is GRANTED.

IT IS FURTHER ORDERED that the Health Care Providers' alternative Motion in Limine is premature and is therefore DENIED WITHOUT PREJUDICE.

IT IS FURTHER ORDERED that United's objections based on undue burden for the At-Issue RFPs and At-Issue Interrogatories are hereby OVERRULED.

IT IS FURTHER ORDERED that United shall produce all Administrative Records for each of the At-Issue Claims on or before September 23, 2020. NLA ~~In the event United does not dispute certain claim information contained in the Claim Spreadsheets, United shall not be required to produce EOBs or PRAs for the particular At-Issue Claims which are undisputed.~~

~~**IT IS FURTHER ORDERED** that United shall timely supplement its production of Administrative Records for each of the At-Issue Claims upon disclosure of new Claim Spreadsheets by the Health Care Providers.~~ NLA

IT IS FURTHER ORDERED that there will be a Status Check on the performance of United's production of those documents set for three weeks from the entry of this order to inform the Judge what production will be possible and when.

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Case No.: A-19-792978-B

Order Granting, In Part Plaintiffs' Motion To Compel Defendants' Production Of Claims File For At-Issue Claims, Or, In The Alternative, Motion In Limine

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~~**IT IS FURTHER ORDERED** that a status check on United's compliance with this Order shall take place on September 30, 3030 at 1:30 p.m~~.

IT IS SO ORDERED.

Dated this 28th day of September, 2020

Nancy L Allf

DISTRICT COURT JUDGE

15B A6E F22F E3DA NB
Nancy Allf
District Court Judge

Submitted by:

McDONALD CARANO LLP

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DISTRICT COURT
CLARK COUNTY, NEVADA

Fremont Emergency Services (Mandavia) Ltd, Plaintiff(s) vs. United Healthcare Insurance Company, Defendant(s)	CASE NO: A-19-792978-B DEPT. NO. Department 27

AUTOMATED CERTIFICATE OF SERVICE

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FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs, vs. UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: A-19-792978-B Dept. No.: XXVII **ERRATA TO PLAINTIFFS' MOTION TO COMPEL DEFENDANTS' LIST OF WITNESSES, PRODUCTION OF DOCUMENTS AND ANSWERS TO INTERROGATORIES**

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Plaintiffs Fremont Emergency Services (Mandavia), Ltd. ("Fremont"); Team Physicians of Nevada-Mandavia, P.C. ("Team Physicians"); Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine ("Ruby Crest" and collectively the "Health Care Providers") submits this Errata to Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories ("Motion to Compel") to include Annex 1 which was inadvertently omitted.

DATED this 28th day of September, 2020.

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 28th day of September, 2020, I caused a true and correct copy of the foregoing **ERRATA TO PLAINTIFFS' MOTION TO COMPEL DEFENDANTS' LIST OF WITNESSES, PRODUCTION OF DOCUMENTS AND ANSWERS TO INTERROGATORIES** to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

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ANNEX 1

I. UNITED'S RESPONSES TO INTERROGATORIES

Interrogatory No. 2:

For the period July 1, 2016 through June 30, 2017, identify in detail the methodology that You used to calculate the amount of Your payment obligation (including both the allowed amount and the amount that You believed that You were obligated to pay) for Emergency Services and Care or Nonemergency Services and Care provided by Non-Participating Providers in Clark County, Nevada. If more than one methodology applied to different portions of a particular CLAIM, please identify in detail each methodology used and explain why different methodologies were used.

Response to Interrogatory No. 2:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff s Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Interrogatory is unduly burdensome and seeks irrelevant information as it is seeking information on the methodology used to determine Defendants' payment obligations to non-parties. Information on the methodology used to determine reimbursement amounts for non-party non-participating providers is not relevant or proportional to the needs of the litigation as many different factors impact the methodology used to determine such amounts. Defendants further object to the relevance of this Interrogatory as it seeks information solely for the period prior to July 1, 2017, which is the earliest claim at issue in this litigation.

To the extent Fremont intended to ask for information related to the methodology Defendants used to calculate the amount that would be paid to Fremont on the claims Fremont is asserting in this litigation from July 1, 2017 to present, Defendants incorporate their response to Interrogatory No. 1. Again, to determine what methodology was used on each of the 15,210 claims Fremont is asserting the Defendants would have to research each individual claim, which is unduly burdensome and not proportional to the needs of the case.

Interrogatory No. 3:

For each CLAIM, identify in detail the methodology that You used to calculate the amount of Your payment obligation (including both the allowed amount and the amount that You believed that You were obligated to pay). If more than one methodology applied to different portions of a particular CLAIM, please identify in detail each methodology used and explain why different methodologies were used.

Response to Interrogatory No. 3:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that the term "CLAIM" is vague, as noted in Defendants' specific objections to Plaintiffs' Definitions, as the definition does not identify what specific list of claims it is referring to. However, Defendants interpret this Interrogatory as referring to the claims listed in FESM000011. Assuming those are the claims Fremont intended to refer to, Defendants object to this Interrogatory on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 CLAIMS where it alleges that Defendants did not reimburse Fremont for the full amount billed. To determine how the reimbursement amount for each CLAIM was determined, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS and analyze it. As explained more fully in the burden declaration attached as **Exhibit 1**, this would be unduly burdensome and not proportional to the needs of the case as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor. Defendants further object to this Interrogatory as it essentially seeks to force Defendants to explain their entire defense

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to Fremont's CLAIMS in narrative form. Courts have held this is an inappropriate use of written discovery and constitutes an inappropriate "blockbuster" interrogatory. *Bashkin v. San Diego Cty*., No. 08-CV-1450-WQH WVG, 2011 WL 109229, at *2 (S.D. Cal. Jan. 13, 2011) ("to the extent Plaintiff seeks every minute detail and narratives about the subject incident and every possible surrounding circumstance, written discovery is not the proper vehicle to obtain such detail."); *Grynberg v. Total S.A.,* No. 03-CV-01280-WYD-BNB, 2006 WL 1186836, at *6 (D. Colo. May 3, 2006) (providing that the use of blockbuster interrogatories that call for every conceivable detail and fact which may relate to a case does not "comport with the just, speedy, and inexpensive determination of the action"). Defendants further respond by incorporating their response to Interrogatory No. 1.

Interrogatory No. 4:

If the payment methodology identified in Your Response to Interrogatory No. 1 above included an assessment of the usual and customary provider charges for similar services in the community or area where the services were provided, identify any providers whose charges You considered in determining the usual and customary charges, including the name, address, telephone number, and medical specialty for each such provider within that community; why You believe that each such provider rendered similar services to those rendered by the hospital; and why You believe that each such provider rendered those services in the same community where the Hospital services were provided. In the event that the methodology identified in Your Response to Interrogatory No. 1 above did not include such an assessment, please explain what alternative metrics You used.

Response to Interrogatory No. 4:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants incorporate by reference their objections and response to Interrogatory No. 1 above.

Interrogatory No. 5:

If You contend that any agreement(s) by and between You and Fremont entitles or entitled You to pay less than Fremont's full billed charges for any of the CLAIMS, or is otherwise relevant to the amounts paid for any of the CLAIMS, identify that agreement, specifying the portion(s) thereof that You contend entitles or entitled You to pay less than Fremont's full billed charges.

Response to Interrogatory No. 5:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff s Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that the term "CLAIM" is vague, as noted in Defendants' specific objections to Plaintiffs' Definitions, as the definition does not identify what specific list of claims it is referring to. However, Defendants interpret this Interrogatory as referring to the claims listed in FESM000011. Assuming those are the claims Fremont intended to refer to, Defendants object to this Interrogatory on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 CLAIMS where it alleges that Defendants did not reimburse Fremont for the full amount billed. To determine how the reimbursement for each CLAIM was determined, including the applicable health benefits plan documents specifying which medical services are covered, the amount of benefits the plan will pay for covered services, or another applicable contract/agreement that may be in place, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS and analyze it. As explained more fully in the burden declaration attached as Exhibit 1, this would be unduly burdensome and not proportional to the needs of the case as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

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Defendants further respond as follows: with respect to the time period after which Fremont became a non-participating out-of-network provider, Defendants are not currently aware of any direct written participation agreement between Defendants and Fremont that would govern the amount of reimbursement (if any) for the CLAIMS. However, there may be other contracts/agreements that governed the amount of reimbursement Fremont received on its CLAIMS, including, but not limited to, the plan documents for the patients that Fremont treated. Defendants are continuing to attempt to determine whether any other contracts/agreements exist and will supplement this response if any are found.

Interrogatory No. 7:

If You rely in whole or in part on the rates from any agreement(s) with any other provider in determining the amount of reimbursement for the CLAIMS, describe in detail such agreement(s), including the rates of reimbursement and other payment scales under those agreements, and any provisions regarding the directing or steerage of Plan Members to those providers.

Response to Interrogatory No. 7:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that the term "CLAIM" is vague, as noted in Defendants' specific objections to Plaintiffs' Definitions, as the definition does not identify what specific list of claims it is referring to. However, Defendants interpret this Interrogatory as referring to the claims listed in FESM000011. Assuming those are the claims Fremont intended to refer to, Defendants object to this Interrogatory on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 CLAIMS where it alleges that Defendants did not reimburse Fremont for the full amount billed. To determine whether agreements with any other provider and/or amounts paid to any other provider would have impacted the determination of the amount of reimbursement for each of the CLAIMS, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS and analyze it. As explained more fully in the burden declaration attached as **Exhibit 1,** this would be unduly burdensome and not proportional to the needs of the case as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Defendants further object to the extent this interrogatory calls for them to reveal information about their agreements with other providers. Defendants' agreements with other providers typically contain confidentiality clauses such that revealing this information could force Defendants to breach their obligations to these third parties. Moreover, the information sought is proprietary and subject to protection as a trade secret pursuant to NRS 600A.030(5) as this information has independent value due to, among other things, the fact that it is not known to other providers like Fremont.

Defendants further respond that, in general, the amounts paid to Fremont would have been based on the terms of the applicable health benefits plan documents specifying which medical services are covered, and the amount of benefits the plan will pay for covered services.

Interrogatory No. 8:

Identify all persons with knowledge of the following subject areas, identifying for each person their name, address, phone number, employer, title, and the subject matter(s) of their knowledge:

(a) The development of the methodology, the materials considered in developing the methodology, and the methodology itself You used to calculate the allowed amount and the amount of Your alleged payment obligations for the CLAIMS in the Clark County Market;

(b) Communications with Fremont regarding the CLAIMS;

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(c) To the extent that You contend or rely on provider charges by other providers to determine Your alleged payment obligation for the CLAIMS, the identity of those other providers, the amount of their charges, and any agreement(s) with those providers regarding those charges.

Response to Interrogatory No. 8:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Interrogatory is overbroad and unduly burdensome to the extent it seeks the identification of "all persons" with knowledge of the particular subject areas. *Mancini v. Ins. Corp. of New York*, No. CIV. 07CV1750-L NLS, 2009 WL 1765295, at *3 (S.D. Cal. June 18, 2009) ("Contention interrogatories are often overly broad and unduly burdensome when they require a party to state "every fact" or "all facts" supporting identified allegations or defenses."); *Bashkin v. San Diego Cty.,* No. 08-CV-1450-WQH WVG, 2011 WL 109229, at *2 (S.D. Cal. Jan. 13, 201 1) ("In the written discovery process, parties are not entitled to each and every detail that could possibly exist in the universe of facts . . . Further, to the extent Plaintiff seeks every minute detail and narratives about the subject incident and every possible surrounding circumstance, written discovery is not the proper vehicle to obtain such detail."). Defendants will not be listing every single person who has any knowledge of the listed topics.

Defendants also object that all three categories listed (a, b and c) are overbroad, vague and by extension unduly burdensome. As to category a, Defendants object that information on the development of the methodology is not relevant to Fremont's claims and not proportional to the needs of the case. Moreover, to identify the persons who would have knowledge of the methodologies used to determine the amount of reimbursement for each of Fremont's 15,210 claims, Defendants would have to pull the administrative record for each of the 15,210 claims, which, as set forth more fully in Defendants' objection to Interrogatory No. 1, would be unduly burdensome and not proportional to the needs of the case.

As to category b, Defendants object that this category is vague, overbroad and unduly burdensome. The number of individuals who may have knowledge of any communications between Defendants and Fremont regarding the 15,210 claims at issue is huge. Defendants request that Fremont narrow this Interrogatory to specific type(s) of communications that will allow Defendants to identify a reasonable number of individuals with information on those specific communications.

As to category c, Defendants object that this category calls for them to reveal information about their agreements with other providers. Defendants' agreements with other providers typically contain confidentiality clauses such that revealing this information could force Defendants to breach their obligations to these third parties. Moreover, the information sought is proprietary and subject to protection as a trade secret pursuant to NRS 600A.030(5) as this information has independent value due to, among other things, the fact that it is not known to other providers like Fremont.

Defendants further object to the extent this interrogatory is intended to force Defendants to name Rule 30(b)(6) witnesses for these categories prior to a Rule 30(b)(6) deposition notice being issued.

Interrogatory No. 9:

Describe in detail Your relationship with Data iSight, including but not limited to the nature of any agreement You have with Data iSight, the scope and extent of the relationship, Your permitted uses of the data provided by Data iSight and the services performed by Data iSight

Response to Interrogatory No. 9:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff s Definitions, Instructions and Rules of Construction, Defendants state as follows:

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Defendants object that this Interrogatory seeks irrelevant information that is not proportional to the needs of the case to the extent it seeks information on Defendants' relationship with Data iSight that does not pertain to how Fremont's claims for payment were adjudicated.

Defendants further respond that pursuant to FRCP 33(d), the answer to the portions of this Interrogatory that are not objectionable may be found by analyzing the contract(s) between United and MultiPlan, Inc. pursuant to which United received pricing information through MultiPlan's Data iSight tool that Defendants are in the process of producing pursuant to Fremont's Request for Production No. 12. The burden of deriving the answer to this Interrogatory by reviewing those contract(s) is substantially the same for either party.

Interrogatory No. 10:

Explain why You ceased using the FAIR Health Database to establish the reasonable value of services and/or usual and customary fees for emergency services in Clark County.

Response to Interrogatory No. 10:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff s Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object to this Interrogatory as it seeks information that appears to not be relevant and also not proportional to the needs of the case. It is unclear how information related to why the Defendants allegedly ceased using the FAIR Health Database would have any impact on either party's claims or defenses. Defendants request that Plaintiff clarify why it believes this request is seeking relevant information in a meet and confer.

Defendants further respond to this Interrogatory that, in general, the amounts paid to Fremont would have been based on the terms of applicable health benefits plan documents specifying which medical services are covered, and the amount of benefits the plan will pay for covered services.

Interrogatory No. 12:

Identify all companies that You have entered into an agreement, contract, subscription or other arrangement by which You receive information regarding usual and customary fees or rates for Emergency Medicine Services provided by Non-Participating Providers or Non-Network Providers in Clark County, Nevada.

Response to Interrogatory No. 12:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Interrogatory is overbroad, seeks irrelevant information, and is unduly burdensome and not proportional to the needs of the case. The Interrogatory asks that all companies be identified regardless of whether the information provided by those companies to the Defendants was actually used to determine the amount of reimbursement for each of Fremont's 15,210 claims. Further, to determine the responsive list of companies, Defendants would have to first retrieve and analyze the administrative record for each of the 15,210 claims, which, as explained more fully in Defendants' objection to Interrogatory No. 1, would be unduly burdensome and not proportional to the needs of the case. Defendants further object that this Interrogatory seeks irrelevant information that is not proportional to the needs of the case to the extent that it seeks information related to usual and customary fees or rates outside of the time period of Fremont's claims (i.e. July 1, 2017 to present).

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II. UNITED'S RESPONSES TO REQUEST FOR PRODUCTION OF DOCUMENTS

Request No. 3:

Produce any and all Documents and/or Communications between You and Fremont regarding any of the CLAIMS.

Response to Request No. 3:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that the term "CLAIM" is vague, as noted in Defendants' objections to Plaintiffs Definitions, as the definition does not identify what specific list of claims it is referring to. However, Defendants interpret this Request as referring to the claims listed in FESM000011. Assuming those are the claims Fremont intended to refer to, Defendants object to this Request on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 CLAIMS where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the documents and communications related to those CLAIMS, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as Exhibit 1, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Defendants further object that all documents and communications exchanged between Defendants and Fremont would necessarily be possessed by Fremont. There is no justification for imposing the burden on Defendants to identify, collect, review, and produce such documents when Fremont already possesses the same.

Request No. 5:

Produce any and all Documents and/or Communications relating to Your determination and/or calculation of the allowed amount and reimbursement for any of the CLAIMS, including the following: (i) the method by which the allowed amount and reimbursement for the Claim was calculated; (ii) the total amount You allowed and agreed to pay; (iii) any contractual or other allowance taken; and (iv) the method, date, and final amount of payment.

Response to Request No. 5:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that the term "CLAIM" is vague, as noted in Defendants' objections to Plaintiffs Definitions, as the definition does not identify what specific list of claims it is referring to. However, Defendants interpret this Request as referring to the claims listed in FESM000011. Assuming those are the claims Fremont intended to refer to, Defendants object to this Request on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 CLAIMS where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the documents and communications related to the four categories set forth in this Request (i.e. (i) the reimbursement methodology, (ii) the total amount allowed and agreed to pay, (iii) any contractual or other allowance taken and (iv) the method, date and final amount of payment), Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as **Exhibit 1**, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Defendants further object to categories (ii), (iii) and (iv) of this Request as they seek information that is equally, if not more accessible, to Fremont. There is no justification for imposing the burden on Defendants to identify, collect, review, and produce such documents

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when Fremont already possesses the same.

Moreover, the request is overbroad, unduly burdensome, not reasonably particular, and not proportional to the needs of the case as it essentially requests all documents related to the parties' claims and defenses. It would be essentially impossible for Defendants to perform the investigation necessary to identify all documents and communications that in someway relate to the determination and calculation of the allowed amounts for all of the 15,210 CLAIMS.

Defendants request that Fremont meet and confer to narrow the scope of this request and provide some semblance of reasonable particularity with respect to the type of documents they are seeking so as to reduce the burden imposed on Defendants.

Request No. 6:

Produce any and all Documents and/or Communications relating to Your decision to reduce payment for any CLAIM.

Response to Request No. 6:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that the term "CLAIM" as vague, as noted in Defendants' objections to Plaintiff s Definitions, as the definition does not identify what specific list of claims it is referring to. However, Defendants interpret this Request as referring to the claims listed in FESM000011. Assuming those are the claims Fremont intended to refer to, Defendants object to this Request on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 CLAIMS where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the documents and communications related to any decision to reduce payment on a CLAIM, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as **Exhibit 1**, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Moreover, the request is overbroad, unduly burdensome, not reasonably particular, and not proportional to the needs of the case as it essentially requests all documents related to the parties' claims and defenses. It would be essentially impossible for Defendants to perform the investigation necessary to identify all documents and communications that in someway relate to the decision to not pay the full billed charges on all of the 15,210 CLAIMS.

Defendants request that Fremont meet and confer to narrow the scope of this request and provide some semblance of reasonable particularity with respect to the type of documents they are seeking so as to reduce the burden imposed on Defendants.

Request No. 7:

Produce any and all Documents and/or Communications supporting or relating to Your contention or belief that You are entitled to pay or allow less than Fremont's full billed charges for any of the CLAIMS.

Response to Request No. 7:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that the term "CLAIM" is vague, as noted in Defendants' objections to Plaintiffs Definitions, as the definition does not identify what specific list of claims it is referring to. However, Defendants interpret this Request as referring to the claims listed in FESM000011. Assuming those are the claims Plaintiff intended to refer to, Defendants object to this Request on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Plaintiff has asserted 15,210 CLAIMS where it alleges that Defendants did not reimburse Plaintiff for the full amount billed. To produce the documents and communications related to any decision to pay or allow less than Plaintiffs full billed charges on a CLAIM, Defendants would, among other things, have to pull the administrative record for each

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of the 15,210 individual CLAIMS, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as **Exhibit 1**, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Moreover, the request is overbroad, unduly burdensome, not reasonably particular, and not proportional to the needs of the case as it essentially requests all documents related to the parties' claims and defenses. It would be essentially impossible for Defendants to perform the investigation necessary to identify all documents and communications that in someway relate to the decision to not pay the full billed charges on all of the 1 5,210 CLAIMS.

Defendants request that Fremont meet and confer to narrow the scope of this request and provide some semblance of reasonable particularity with respect to the type of documents they are seeking so as to reduce the burden imposed on Defendants.

Request No. 8:

If you contend that any course of prior business dealing(s) by and between You and Fremont entitle(s) You to pay less than Fremont's full billed charges for any of the CLAIMS, or is otherwise relevant to the amounts paid for any of the CLAIMS, produce any Documents and/or Communications relating to any such prior course of business dealing(s).

Response to Request No. 8:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that the phrase "prior business dealing(s)" is vague. Defendants are not certain what is intended by this phrase and are thus unable to determine whether or not they would make the contention referenced in this Request (i.e. is Fremont referring to prior payments by Defendants to Fremont, prior contracts between Defendants and Fremont, etc.). Defendants request clarification as what is meant by this phrase and Defendants will then supplement their response to this Request, if supplementation is warranted.

Defendants further object that documentation of prior business dealings between Defendants and Fremont would necessarily be possessed by Fremont. There is no justification for imposing the burden on Defendants to identify, collect, review, and produce such documents when Fremont already possesses the same.

Request No. 9:

If you contend that any agreement(s) by and between You and Fremont entitles You to pay less than Fremont's full billed charges for any of the CLAIMS, or is otherwise relevant to the amounts paid for any of the CLAIMS, produce any Documents and/or Communications relating to any such agreement(s).

Response to Request No. 9:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows: During the time period after which Fremont became a non-participating, out-of-network provider, Defendants are not currently aware of any direct written participation agreement between Defendants and Fremont that would govern the amount of reimbursement (if any) for the CLAIMS. However, there may be other contracts/agreements that governed the amount of reimbursement for each CLAIM, including, but not limited to, the applicable health benefits plan Defendants are continuing to attempt to determine whether any such contracts/agreements exist and will supplement this response, if any such contracts or agreements are found.

Request No. 10:

Produce any and all Documents and/or Communications relating to the methodology You currently use, or used during calendar or Plan years 2016, 2017, 2018 and/or 2019 to determine and/or calculate Your reimbursement of Non-Participating Providers in Nevada for Emergency Medicine Services.

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Response to Request No. 10:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that this Request is overbroad, unduly burdensome and seeks information that is not relevant and not proportional to the needs of the case. This Request is overbroad as it seeks information on methodologies used prior to July 1, 2017 (the date of the first claim Fremont is asserting). This Request is also overbroad as it seeks information on the methodologies used to calculate reimbursement rates for all non-participating emergency services providers in Nevada, as opposed to being limited to information related to methodologies used to calculate the rate of reimbursement on the claims Fremont is asserting in this litigation. The information sought in this Request is also not relevant as Defendants often use different reimbursement methodologies depending on, for example, the particular claim, provider, and/or the applicable health benefits plan documents.

Defendants request that Fremont meet and confer to narrow the scope of this Request to ensure that it is not unduly burdensome to Defendants and that Fremont is able to get the information it is seeking.

Request No. 11:

Produce all Documents and/or Communications between You and any third-party, including but not limited to Data iSight, relating to (a) any claim for payment for medical services rendered by Fremont to any Plan Member, or (b) any medical services rendered by Fremont to any Plan Member.

Response to Request No. 11:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that this Request is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 claims where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the documents and communications that may have been exchanged between Defendants, Data iSight, and other third parties related to these claims and medical services, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as **Exhibit 1**, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor. Defendants further object that this Request is vague and overbroad to the extent it seeks documents and communications with unnamed "third parties" beyond Data iSight. Defendants will not be producing "all" documents and communications with Data iSight and these unnamed third parties.

Defendants further respond that they will produce the relevant contract(s) between United and MultiPlan, Inc. pursuant to which United received pricing information through MultiPlan's Data iSight tool, redacted as necessary to protect irrelevant propriety information, on or about February 26, 2020. Defendants further state that, while they believe they can meet this deadline, their ability to meet it is partially dependent on the cooperation of third parties.

Supplemental Response to Request No. 11:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that this Request is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 claims where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the documents and communications that may have been exchanged between Defendants, Data iSight, and other third parties related to these claims and medical services, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS, review the

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records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as Exhibit 1, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor. Defendants further object that this Request is vague and overbroad to the extent it seeks documents and communications with unnamed "third parties" beyond Data iSight. Defendants will not be producing "all" documents and communications with Data iSight and these unnamed third parties.

Defendants further respond that they will produce the relevant contract(s) between United and MultiPlan, Inc. pursuant to which United received pricing information through MultiPlan's Data iSight tool, redacted as necessary to protect irrelevant propriety information. *See* **DEF000722-DEF000854**.[1]

Request No. 12:

Produce all Documents identifying and describing all products or services Data iSight, provides to You with respect to Your Health Plans issued in Nevada or any other state, including without limitation repricing services provided to You, whether You adjudicated and paid any claims in accordance with re-pricing information recommended by Data iSight, and the appeals administration services provided to You.

Response to Request No. 12:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that this Request is unduly burdensome and seeks information that is not proportional to the needs of the case to the extent it asks for information on "whether You adjudicated and paid any Claims in accordance with re-pricing information recommended by Data iSight." Fremont has asserted 15,210 claims where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the documents related to whether information from Data iSight impacted how any of the 15,210 claims were reimbursed, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual claims, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as **Exhibit 1**, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Defendants further object to the portion of this Request that seeks information on "all products or services Data iSight provides to You." This portion of this Request appears to seek information that is not relevant to any of Plaintiffs claims and that is not proportional to the needs of the case as not all services Data iSight provides relate to Plaintiffs claims. No documents will produced in response to this portion of this Request.

Defendants further respond that they will produce the relevant contract(s) between United and MultiPlan, Inc. pursuant to which United received pricing information through MultiPlan's Data iSight tool, redacted as necessary to protect irrelevant propriety information, on or about February 26, 2020. Defendants further state that, while they believe they can meet this deadline, their ability to meet it is partially dependent on the cooperation of third parties.

For the other aspects of this Request that were objected to, Defendants request that Plaintiff meet and confer to narrow the scope of this Request to ensure that it is not unduly burdensome to Defendants, seeks relevant information and that Plaintiff is able to get the information it is seeking.

Request No. 13:

Produce all Documents and/or Communications concerning, evidencing, or relating to any negotiations or discussions concerning Non-Participating Provider reimbursement rates between You and Fremont, including, without limitation, documents and/or communications relating to the meeting in or around December 2017 between You, including, but not limited to, Dan Rosenthal,

[1] This Bates-range represents the MultiPlan Agreement.

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John Haben, and Greg Dosedel, and Fremont, where Defendants proposed new benchmark pricing program and new contractual rates.

Response to Request No. 13:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that this Request is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 claims where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the documents and communications that relate to any discussions or negotiations over the reimbursement rates on those claims, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual claims, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as **Exhibit 1**, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Moreover, all documents and communications exchanged between Defendants and Fremont would necessarily be possessed by Fremont. There is no justification for imposing the burden on Defendants to identify, collect, review, and produce such documents when Fremont already possesses the same.

Defendants further respond by referring Fremont to the following bates numbered documents produced with these responses that relate to negotiations between Fremont and the Sierra Defendants: **DEF000114 - DEF000156**. Defendants are in the process of collecting responsive document that relate to negotiations between Fremont and the other Defendants will produce those documents by February 26, 2020.

For the other aspects of this Request that were objected to, Defendants request that Plaintiff meet and confer to narrow the scope of this Request to ensure that it is not unduly burdensome to Defendants, seeks relevant information and that Plaintiff is able to get the information it is seeking.

Request No. 14:

Produce all Documents regarding rates insurers and/or payors other than You have paid for Emergency Services and Care in Nevada to either or both Participating or Non-Participating Providers from July 1, 2016, to the present.

Response to Request No. 14:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that this Request seeks information that is not within its possession, custody or control. To the extent Plaintiff believes this information would be within Defendants' possession, custody or control, Defendants request that Plaintiff clarify this Request. Defendants further object that this Request is overbroad and unduly burdensome as it appears to seek documents on all emergency medical services claims that have ever been paid by any insurer or payor in Nevada during the specified time frame. Thus, the Request likely covers hundreds of thousands of claims for payment and seeks information that is not proportional to the needs of this litigation. Defendants further object that this Request is overbroad as it seeks information starting on July 1, 2016, but the earliest claim Fremont has asserted is dated July 1, 2017. Defendants further state that to the extent Defendants do have any responsive documents these document would likely be publicly available to Plaintiff as well.

Request No. 15:

Produce all Documents and/or Communications, reflecting, analyzing, or discussing the methodology you used to calculate or determine Non-Participating Provider reimbursement rates for Emergency Services in Nevada, including, but not limited to, any documents and/or communications you used or created in the process of calculating and/or determining the

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prevailing charges, the reasonable and customary charges, the usual and customary charges, the average area charges, the reasonable value, and/or the fair market value for Emergency Services in Clark County.

Response to Request No. 15:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that this Request is overbroad, unduly burdensome and seeks information that is not relevant and not proportional to the needs of the case since it is not limited to a specific time frame and/or not limited to the methodology used to calculate reimbursement rates for emergency services provided by Fremont, as opposed to other non-party emergency services providers. Rather, this improper Request appears to seek documents and communications relating to rates of reimbursement to providers other than Fremont.

A portion of this Request does seek relevant information as Fremont is a nonparticipating provider that provides emergency services in Nevada. However, that portion of this Request, as currently framed, is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 claims where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the documents and communications that relate to the methodology used to calculate the amount of reimbursement paid on Fremont's claims, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual claims, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as **Exhibit 1** to, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Defendants request that Plaintiff meet and confer to narrow the scope of this Request to ensure that it is not unduly burdensome to Defendants and that Plaintiff is able to get the information it is seeking.

Request No. 16:

Produce all Documents that refer, relate or otherwise reflect shared savings programs in Nevada for Fremont's out-of-network claims from July 1, 2017 to present. This request includes, without limitation, contracts with third parties regarding Your shared savings program, amounts invoiced by You to third parties for the shared savings program for Fremont's out-of-network claims, amount You were compensated for the shared savings program for Fremont's out-of-network claims.

Response to Request No. 16:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that this Request seeks information that is not relevant to Plaintiffs claims and not proportional to the needs of the case. Defendants further object that this Request is vague in regard to what is meant by "shared savings programs." Defendants request that Plaintiff clarify what is meant by this term so that Defendants can determine whether they have responsive documents in their possession.

Defendants further object that this Request is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 claims where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the documents that relate to amounts invoiced to third parties for those claims and amounts received by Defendants, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual claims, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as **Exhibit 1**, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Defendants request that Plaintiff meet and confer to narrow the scope of this Request to ensure that it is not unduly burdensome to Defendants and that Plaintiff is able to get the information it is seeking.

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Request No. 17:

All Communications between You and any third-party, relating to (a) any CLAIM for payment for medical services rendered by Fremont to any Plan Member, or (b) any medical services rendered by Fremont to any Plan Member.

Response to Request No. 17:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that the term "CLAIM" is vague, as noted in Defendants' objections to Plaintiffs Definitions, as the definition does not identify what specific list of claims it is referring to. However, Defendants interpret this Request as referring to the claims listed in FESM000011. Assuming those are the claims Fremont intended to refer to, Defendants object to this Request on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 CLAIMS where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the communications between Defendants and third parties related to those CLAIMS, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as **Exhibit 1**, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Defendants request that Plaintiff meet and confer to narrow the scope of this Request to ensure that it is not unduly burdensome to Defendants and that Plaintiff is able to get the information it is seeking.

Request No. 18:

All documents and/or communications regarding the rational, basis, or justification for the reduced rates for emergency services proposed to Fremont in or around 2017 to Present.

Response to Request No. 18:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object to this Request on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 claims where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the documents related to why those claims were paid at a particulate rate, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as **Exhibit 1**, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Moreover, the request is overbroad, unduly burdensome, not reasonably particular, and not proportional to the needs of the case as it essentially requests all documents related to the parties' claims and defenses. It would be essentially impossible for Defendants to perform the investigation necessary to identify all documents and communications that in someway relate to the justification for the payments made on all of the 15,210 CLAIMS.

Defendants request that Fremont meet and confer to narrow the scope of this request and provide some semblance of reasonable particularity with respect to the type of documents they are seeking so as to reduce the burden imposed on Defendants.

Request No. 19:

All documents regarding the Provider charges and/or reimbursement rates that You have paid to Participating or Non-Participating Providers from July 1, 2017, to the present in Nevada. Without waiving any right to seek further categories of documentation, at this juncture, Fremont is willing to accept, in lieu of contractual documents, data which is blinded or redacted and/or aggregated or summarized form.

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Response to Request No. 19:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that, even with the limitation proposed by Fremont, this Request is overbroad, unduly burdensome and seeks irrelevant information that is not proportional to the needs of the case. It is unclear what the relevance is of documents showing what the amounts Defendants paid to providers other than Fremont. Depending on, for example, the provider, the claim at issue, and/or the applicable health benefits plan documents, Defendants use different methodologies to calculate the allowed amount of reimbursement. The documents sought in this Request are therefore not relevant to determining the usual and customary rate of reimbursement for the claims Fremont is asserting in this litigation. To the extent this Request is also seeking documents related to the reimbursement rates for claims of Fremont as a Non-Participating Provider, Defendants object to this Request on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 claims where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the documents relating to the reimbursement rates on those claims, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as **Exhibit 1**, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Defendants request that Plaintiff meet and confer to explain the relevancy of the information sought in this Request and to narrow the scope of this Request to ensure that it is not unduly burdensome to Defendants and that Plaintiff is able to get the information it is seeking.

Request No. 20:

All Documents relied on for the determination of the recommended rate of reimbursement for any CLAIM by Fremont for payment for services rendered to any Plan Member. This request includes, without limitation, all cost data, reimbursement data, and other data and Documents upon which such recommended rates are based.

Response to Request No. 20:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that the term "CLAIM" is vague, as noted in Defendants' objections to Plaintiffs Definitions, as the definition does not identify what specific list of claims it is referring to. However, Defendants interpret this Request as referring to the claims listed in FESM000011. Assuming those are the claims Fremont intended to refer to, Defendants object to this Request on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 CLAIMS where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the documents relied on to determine the amount of reimbursement to be issued on a CLAIM, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as **Exhibit 1**, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Moreover, the request is overbroad, unduly burdensome, not reasonably particular, and not proportional to the needs of the case as it essentially requests all documents related to the parties' claims and defenses. It would be essentially impossible for Defendants to perform the investigation necessary to identify all documents and communications that in someway relate to the reimbursement issued to Fremont on all of the 15,210 CLAIMS.

Defendants request that Fremont meet and confer to narrow the scope of this request and provide some semblance of reasonable particularity with respect to the type of documents they are seeking so as to reduce the burden imposed on Defendants.

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Request No. 21:

All Documents relating to Your relationship [to] Data iSight, including any and all agreements between You and Data iSight, and any and all documents that explain the scope and extent of the relationship, Your permitted uses of the data provided by Data iSight, and the services performed by Data iSight.

Supplemental Response:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that this Request is overbroad, unduly burdensome and seeks facts that are not relevant Plaintiff's claims and not proportional to the needs of the case, as it seeks "all agreements" and "all documents" regardless of whether they relate to Plaintiff's claims.

Defendants further respond that they will produce the relevant contract(s) between United and MultiPlan, Inc. pursuant to which United received pricing information through MultiPlan' s Data iSight tool, redacted as necessary to protect irrelevant propriety information. *See* **DEF000722-DEF000854**.

Request No. 22:

Produce any and all Documents and/or Communications relating to any analysis of the usual and customary provider charges for similar services in Nevada for Emergency Medicine Services.

Response to Request No. 22:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request is vague in regard to what type of "analysis" it is referring to and vague in regard to what "similar services" it is referring to. Defendants are thus unable to determine whether they have documents that are responsive to this Request. Defendants further object that this Request appears to be overbroad, unduly burdensome and seeks information that is not relevant to Plaintiffs claims and not proportional to the needs of the case.

Defendants request that Plaintiff meet and confer to narrow the scope of this Request to ensure that it is not unduly burdensome to Defendants and that Plaintiff is able to get the information it is seeking.

Request No. 23:

Produce any and all Documents and/or Communications relating to any analysis of any Nevada statutes or guidelines You currently use, or used during calendar or Plan years 2016, 2017, 2018 and/or 2019, to determine and/or calculate Your reimbursement of Non-Participating Providers in Nevada for Emergency Medicine Services.

Response to Request No. 23:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that this Request is overbroad, unduly burdensome and seeks information that is not relevant to Plaintiffs claims and not proportional to the needs of the case. This improper Request seeks documents and communications relating to reimbursement

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calculations for all non-participating providers in Nevada rather than just Fremont. Defendants further object that this Request is vague in referring to "any Nevada statutes or guidelines" rather than to specific statutes. This vagueness, in turn, makes it unduly burdensome for Defendants to find responsive documents. Further, this Request appears to potentially call for information that is subject to the attorney-client and/or work product privileges as it is seeking analysis of Nevada statutes and guidelines. Defendants further object to the extend this Request seeks information from prior to July 1, 2017, the date of the earliest claim submitted by Fremont, as such information is not relevant to Plaintiffs claims.

To the extent that Fremont intended this Request to refer to NRS 679B.152, Defendants incorporate by reference their responses to requests for production nos. 1 and 2.

Defendants request that Plaintiff meet and confer to narrow the scope of this Request to ensure that it is not unduly burdensome to Defendants and that Plaintiff is able to get the information it is seeking.

Request No. 25:

Produce all agreements between You and any Participating Providers in Nevada relating to the provision of Emergency Medicine Services to Plan Members.

Response to Request No. 25:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request seeks information that is not relevant to Plaintiffs claims and not proportional to the needs of the case. Fremont is a non-participating provider and thus Defendants' contracts with participating providers are not relevant. Defendants further object that this Request is not limited to any specific time period.

Defendants also object that this Request improperly asks that they reveal information about their agreements with other providers. Defendants' agreements with other providers typically contain confidentiality clauses such that producing these agreements could force Defendants to breach their obligations to these third parties. Moreover, the information sought is proprietary and subject to protection as a trade secret pursuant to NRS 600A.030(5) as this information has independent value due to, among other things, the fact that it is not known to other providers like Fremont.

Request No. 26:

Produce any and all Documents and/or Communications regarding the provider charges and/or reimbursement rates that other insurers and/or payors have paid for Emergency Medicine Services in Nevada to either or both participating or non-participating providers from January 1, 2016, to the present, including Documents and/or Communications containing any such data or information produced in a blinded or redacted form and/or aggregated or summarized form.

Response to Request No. 26:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request seeks information that is not within its possession, custody or control. To the extent Plaintiff believes this information would be within Defendants' possession, custody or control, Defendants request that Plaintiff clarify its Request. Defendants further object that this Request is overbroad and unduly burdensome as it appears to seek

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documents on all emergency medical services claims that have ever been paid by any insurer or payor in Nevada during the specified time frame. Thus, the Request likely covers hundreds of thousands of claims for payment and seeks information that is not proportional to the needs of this litigation. Defendants further object that this Request is overbroad and seeks irrelevant information as it seeks information starting on July 1, 2016 but the earliest claim Plaintiff has asserted is dated July 1, 2017. Defendants further state that to the extent Defendants do have any responsive documents these document would likely be publicly available to Fremont as well.

Request No.27:

Produce any and All Documents and/or Communications concerning, evidencing, or relating to any negotiations or discussions concerning non-participating provider reimbursement rates between the UH Parties and Fremont, including negotiations or discussions leading up to any participation agreements or contracts with Fremont in effect prior to July 1, 2017.

Response to Request No. 27:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object to this Request to the extent that it seeks documents and communications from prior to July 1, 2017 as this portion of the Request seeks information that is not relevant to Fremont's claims and that is not proportional to the needs of the case. Defendants will not be providing documents that are responsive to this portion of the Request.

Moreover, all documents and communications exchanged between Defendants and Fremont would necessarily be possessed by Fremont. There is no justification for imposing the burden on Defendants to identify, collect, review, and produce such documents when Fremont already possesses the same.

Defendants further respond that they are in the process of attempting to locate responsive documents and intend to produce said documents on February 26, 2020.

Supplemental Response:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object to this Request to the extent that it seeks documents and communications from prior to July 1, 2017 as this portion of the Request seeks information that is not relevant to Fremont's claims and that is not proportional to the needs of the case. Defendants will not be providing documents that are responsive to this portion of the Request.

Moreover, all documents and communications exchanged between Defendants and Fremont would necessarily be possessed by Fremont. There is no justification for imposing the burden on Defendants to identify, collect, review, and produce such documents when Fremont already possesses the same.

Defendants have been unable to locate documents relating to rate negotiations between Fremont Emergency Services (MANDAVIA) Ltd. and the other Defendants but will supplement this response and produce same if any such documents are located.

Request No. 28:

Produce any and All Documents and/or Communications concerning, evidencing, or relating to any negotiations or discussions concerning non-participating provider reimbursement

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rates between the Sierra Affiliates and Fremont, including negotiations or discussions leading up to any participation agreements or contracts with Fremont in effect prior to March 1, 2019.

Response to Request No. 28:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object to this Request to the extent that it seeks documents and communications from prior to March 1, 2019 as this portion of the Request seeks information that is not relevant to Plaintiff's claims and that is not proportional to the needs of the case. Defendants will not be providing documents that are responsive to this portion of the Request.

Moreover, all documents and communications exchanged between Defendants and Fremont would necessarily be possessed by Fremont. There is no justification for imposing the burden on Defendants to identify, collect, review, and produce such documents when Fremont already possesses the same.

Defendants further respond by referring Plaintiff to the following bates numbered documents produced with these responses: **DEF000114-DEF000156.**

Request No. 29:

Produce any and all contracts and participation agreements that You have or had with any Emergency Medicine Groups and/or any hospitals or other providers of Emergency Department Services other than Fremont that were in effect at any point from January 1, 2016, through the present, including all fee or rate schedules and amendments and addendums, and all other documents reflecting the agreed-upon terms for reimbursement for any product or service.

Response to Request No. 29:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request seeks information that is not relevant to Plaintiffs claims and not proportional to the needs of the case. Fremont is a non-participating provider and thus Defendants' contracts with participating providers are not relevant. Defendants further object that this Request seeks irrelevant information as it is seeking information from prior to July 1, 2017, the date of the earliest claim asserted by Plaintiff.

Defendants also object that this Request improperly asks that they reveal information about their agreements with other providers. Defendants' agreements with other providers typically contain confidentiality clauses such that producing these agreements could force Defendants to breach their obligations to these third parties. Moreover, the information sought is proprietary and subject to protection as a trade secret pursuant to NRS 600A.030(5) as this information has independent value due to, among other things, the fact that it is not known to other providers like Fremont.

Request No. 30:

Produce any and all Documents and/or Communications between You and any Emergency Medicine Groups and/or any hospitals or other providers of Emergency Department Services other than Fremont occurring at any point from January 1, 2016, through the present relating to negotiations of any reimbursement rates and/or fee schedules for Emergency Medicine Services and/or Emergency Department Services.

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Response to Request No. 30:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request seeks information that is not relevant to Plaintiffs claims and not proportional to the needs of the case. This request seeks a substantial amount of information regarding Defendants' negotiations, relationship, and rates of reimbursement to numerous non-parties which has relevance to Plaintiff's claims. Defendants further object that this Request seeks irrelevant information as it is seeking information from prior to July 1, 2017, the date of the earliest claim asserted by Plaintiff.

Defendants also object that this Request improperly asks that they reveal information about their agreements with other providers. Defendants' agreements with other providers typically contain confidentiality clauses such that producing these agreements could force Defendants to breach their obligations to these third parties. Moreover, the information sought is proprietary and subject to protection as a trade secret pursuant to NRS 600A.030(5) as this information has independent value due to, among other things, the fact that it is not known to other providers like Fremont.

Request No. 31:

Produce any and all Documents and/or Communications regarding Your goals, thoughts, discussions, considerations, and/or strategy regarding reimbursement rates and/or fee schedules for participating Emergency Medicine Groups and/or any hospitals or other providers of Emergency Department Services from January 1, 2015, through the present.

Response to Request No. 31:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request is overbroad, unduly burdensome and seeks information that is not relevant to Plaintiffs claims and not proportional to the needs of the case. This request seeks a substantial amount of information regarding Defendants' negotiations, relationship, and rates of reimbursement to numerous non-parties which has relevance to Plaintiff's claims. Defendants further object that this Request seeks irrelevant information from prior to July 1, 2017 as Plaintiff is not asserting any claims for services prior to that date. Defendants further object that, as written, this Request is vague and it is unclear exactly what documents would be responsive to this Request. Defendants further object that, since this Request refers to defendants' "goals." "thoughts," and "strategy," it may be seeking information that is protected by the attorney-client and/or attorney work product privileges.

Defendants also object that this Request improperly asks that they reveal information about their agreements with other providers. Defendants' agreements with other providers typically contain confidentiality clauses such that producing these agreements could force Defendants to breach their obligations to these third parties. Moreover, the information sought is proprietary and subject to protection as a trade secret pursuant to NRS 600A.030(5) as this information has independent value due to, among other things, the fact that it is not known to other providers like Fremont.

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Request No. 32:

Produce any and all Documents and/or Communications regarding Your goals, thoughts, discussions, considerations, and/or strategy regarding reimbursement rates and/or fee schedules for non-participating Emergency Medicine Groups and/or any hospitals or other providers of Emergency Department Services from January 1, 2016, through the present.

Response to Request No. 32:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request is overbroad, unduly burdensome and seeks information that is not relevant to Plaintiffs claims and not proportional to the needs of the case. This Request seeks a substantial amount of information regarding Defendants' negotiations, strategy, relationship, and rates of reimbursement to numerous non-parties which has no relevance to Plaintiffs claims. Defendants further object that this Request seeks irrelevant information to the extent this Request seeks information from prior to July 1, 2017 as Fremont is not asserting any claims for services prior to that date. Defendants further object that, as written, this Request is vague and it is unclear exactly what documents would be responsive to this Request. Defendants further object that, since this Request refers to Defendants' "goals." "thoughts," and "strategy," it may be seeking information that is protected by the attorney-client and/or attorney work product privileges.

Defendants also object that this Request improperly asks that they reveal information about their agreements with other providers. Defendants' agreements with other providers typically contain confidentiality clauses such that producing these agreements could force Defendants to breach their obligations to these third parties. Moreover, the information sought is proprietary and subject to protection as a trade secret pursuant to NRS 600A. 030(5) as this information has independent value due to, among other things, the fact that it is not known to other providers like Fremont.

Request No. 33:

Produce any and all Documents and/or Communications regarding Your reimbursement rates paid or to be paid to out-of-network Emergency Medicine Groups and/or complaints about Your level of payment for Emergency Medicine Services and/or Emergency Department Services received from out-of-network providers.

Response to Request No. 33:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request is overbroad, unduly burdensome and seeks information that is not relevant to Plaintiffs claims and not proportional to the needs of the case. This Request seeks a substantial amount of information regarding Defendants' rates of reimbursement to numerous non-parties which has no relevance to Plaintiffs claims. Defendants further object that this Request is overbroad since it is not limited to any specific time period. The term "Complaints" is also vague and overbroad, as noted in Defendants' objections to Plaintiffs Definitions. Indeed, as written, this Request appears to call for Defendants to produce any communication from any out of network provider to Defendants where the provider complains in any way about payment, regardless of when that communication was sent. There

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are likely hundreds of thousands if not millions of documents that could be responsive to this Request.

Defendants also object that this Request improperly asks that they reveal information about their agreements with other providers. Defendants' agreements with other providers typically contain confidentiality clauses such that producing these agreements could force Defendants to breach their obligations to these third parties. Moreover, the information sought is proprietary and subject to protection as a trade secret pursuant to NRS 600A.030(5) as this information has independent value due to, among other things, the fact that it is not known to other providers like Fremont

Request No. 34:

Produce any and all Documents and/or Communications regarding the impact, if any, that reimbursement rates paid by You to non-participating providers have had on profits You earned and/or premiums You charged with respect to one or more of Your commercial health plans offered in the State of Nevada from 2016 to the present.

Response to Request No. 34:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request is overbroad, unduly burdensome and seeks information that is not relevant to Plaintiffs claims and not proportional to the needs of the case. This Request is overbroad in that it is not limited to the impact of reimbursement rates paid to Fremont on Defendants profits but rather includes numerous non-party non-participating providers. This Request also seeks irrelevant information as the impact of reimbursement rates to numerous non-parties (or to Plaintiff for that matter) on Defendants' profits has no bearing on whether or not Fremont was reimbursed at the appropriate rate for the services it provided to Defendants' plan members. This Request is also overbroad and seeks irrelevant information to the extent it seeks information from prior to July 1, 2017, which is the date of the earliest claim asserted by Plaintiff in this litigation.

In addition, this Request is objectionable as it infringes on Defendants' privacy interests and seeks proprietary and confidential business information that the Defendants are entitled to shield from disclosure. *Ranney-Brown Distributors, Inc. v. E. T. Barwick Indus., Inc.,* 75 F.R.D. 3, 5 (S.D. Ohio 1977) ("Ordinarily, Rule 26 will not permit the discovery of facts concerning a defendant's financial status, or ability to satisfy a judgment, since such matters are not relevant, and cannot lead to the discovery of admissible evidence."); *U.S. for the Use and Benefit of P. W. Berry Co. v. Gen. Elec. Co.*, 158 F.R.D. 161, 164 (D.Or.1994) (granting motion for protective order in a breach of contract action, precluding discovery of corporate and individual financial information including tax returns and financial statements, because that information was not relevant within the meaning of Rule 26(b)(1)) when the core of the parties' dispute was over whether or not the plaintiff had been adequately compensated for the work it performed).

Moreover, this information is subject to protection as a trade secret pursuant to NRS 600A. 030(5) as this information has independent value due to, among other things, the fact that it is not known to other providers like Fremont.

Request No. 35:

Produce any and all Documents and/or Communications regarding Your reimbursement policies for non-participating providers considered or adopted, effective January 1, 2016, to the present.

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Response to Request No. 35:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request is overbroad and seeks information that is not relevant and not proportional to the needs of the case. This Request is overbroad in that it seeks reimbursement policies for all non-participating providers rather than just those that would apply to Plaintiff. It is also overbroad in that it seeks documents from prior to July 1, 2017, which is the date of the earliest claim asserted by Plaintiff.

Defendants also object that the term "reimbursement policies" is unreasonably vague and could arguably apply to numerous irrelevant documents. In general, the amounts paid to nonparticipating providers are based on the terms of the applicable health benefits plan documents. It is unclear if these are the documents Fremont is seeking or if Fremont is seeking something else. Defendants request that Plaintiff meet and confer to narrow the scope of this Request to ensure that it is not unduly burdensome to Defendants and that Plaintiff is able to get the information it is seeking.

Request No. 36:

Produce any and all Documents and/or Communications regarding or reflecting the average or typical rate of payment, or an aggregation, summary or synopsis of those payments, that You allowed from January 1, 2016, to the present for all or any portion of the Emergency Medicine Services and/or Emergency Department Services rendered to Your Plan Members covered under any plan You offer in Nevada.

Response to Request No. 36:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request is overbroad, unduly burdensome and seeks information that is not relevant to Plaintiffs claims and not proportional to the needs of the case. his Request seeks a substantial amount of information regarding Defendants' rates of payment to numerous non-parties which has no relevance to Plaintiffs claims. Defendants further object that this Request is overbroad since it seeks documents from prior to July 1, 2017, which is the date of the earliest claim asserted by Plaintiff. Indeed, as written, this Request calls for the production of documents and communications relating to "any plan" the Defendants have offered in Nevada in the last four years, regardless of whether Fremont ever treated any of those plan members. There are likely hundreds of thousands if not millions of documents that could be responsive to this Request.

Defendants also object that this Request improperly asks that they reveal information about their payments to other providers. Defendants' agreements with other providers typically contain confidentiality clauses such that producing this information could force Defendants to breach their obligations to these third parties. Moreover, the information sought is proprietary and subject to protection as a trade secret pursuant to NRS 600A.030(5) as this information has independent value due to, among other things, the fact that it is not known to other providers like Fremont.

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Request No. 38:

Produce any and all Documents and/or Communications concerning Your adjudication and/or payment of each claim for Emergency Medicine Services and/or Emergency Department Services that either participating or non-participating Emergency Medical Groups and/or any hospitals or other providers of Emergency Department Services other than Fremont submitted to You for payment between January 1, 2016, and the present.

Response to Request No. 38:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

In regard to documents and communications that would have been made available to plan members, Defendants object to this Request on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Plaintiff has asserted 15,210 claims where it alleges that Defendants did not reimburse Fremont for the full amount billed. To locate the documents and communications related to reimbursement of out-of-network services that would have been made available to plan members, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual claims and review those records for responsive documents. As explained more fully in the burden declaration attached as Exhibit 1, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim record for a total of 30,420 hours of employee labor.

Defendants further object to the extent this Request seeks information from prior to July 1, 2017 as such information is not relevant to Plaintiffs claims and is not proportional to the needs of the case.

In regard to documents made available to Emergency Medicine Groups, Defendants refer Plaintiff to the following bates numbered documents that may be potentially responsive: **DEF000157-DEF000721**. Defendants are continuing to search for additional responsive documents and will supplement this response on or about February 26, 2020.

In regard to the portions of this Request that were objected to, Defendants request that Plaintiff meet and confer to narrow the scope of this Request to ensure that it is not unduly burdensome to Defendants, seeks relevant information and that Plaintiff is able to get the information it is seeking.

Request No .41:

Produce any and all Documents and/or Communications regarding any challenges by any other non-participating Emergency Medicine Group and/or any non-participating hospital or other non-participating provider of Emergency Department Services of the appropriateness of the reimbursement rates paid by You for Emergency Medicine Services and/or Emergency Department Services rendered to Your Plan Members from January 1, 2016, to the present.

Response to Request No. 41:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request is overbroad, unduly burdensome and seeks information that is not relevant to Plaintiffs claims and not proportional to the needs of the case. This Request seeks "all documents and/or communications" relating to challenges by non-parties

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to Defendants' rates of reimbursement. Such information has no relevance to Plaintiffs claims. Defendants further object that this Request is overbroad since it seeks information from prior to July 1, 2017, the date of the earliest claim asserted by Plaintiff. The term "challenges" is also vague and overbroad in that it is unclear what type of challenges are intended to be encompassed by it (i.e. legal complaint, administrative appeals, other types of "challenges," etc.). Indeed, as written, this Request could be read to call for Defendants to produce any communication from any out of network provider to Defendants where the provider complains in any way about payment

Request No .42:

Produce any and all Documents and/or Communications regarding, discussing, or referring to any failure by You to attempt to effectuate a prompt, fair, and/or equitable settlement of any CLAIMS.

Response to Request No. 42:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that the phrase "attempt to effectuate a prompt, fair, and/or equitable settlement of any CLAIMS" is vague as it is unclear exactly what type of failure by Defendants would make a document and/or communication responsive.

Defendants further object that the term "CLAIM" is vague, as noted in Defendants' objections to Plaintiffs Definitions, as the definition does not identify what specific list of claims it is referring to. However, Defendants interpret this Request as referring to the claims listed in FESM00001 1. Assuming those are the claims Plaintiff intended to refer to, Defendants object to this Request on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Plaintiff has asserted 15,210 CLAIMS where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the documents and communications relating to any legal analysis that impacted the amount paid on those CLAIMS (assuming such documents even exist), Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as Exhibit 1, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Defendants request that Plaintiff meet and confer to narrow the scope of this Request to ensure that it is not unduly burdensome to Defendants and that Plaintiff is able to get the information it is seeking.

Request No. 43:

Produce any and all Documents and/or Communications suggesting that Medicare reimbursement rate for any Emergency Medicine Services is not a measure of either fair market value or the usual and customary rate for such services.

Response to Request No. 43:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request is vague, overbroad, and, by extension, unduly burdensome. Defendants are uncertain what is meant by the phrase "suggesting that Medicare reimbursement rate ... is not a measure of either fair market value or the usual and customary rate for such services" and request that Plaintiff clarify exactly what type of documents and communications it is seeking.

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This Request is overbroad and unduly burdensome in that it is not limited to communications from any particular person or entity and is not limited in time frame. As written, the Request would require the Defendants to essentially search all their records and databases all over the country for any comments relating to "Medicare," "fair market value" and "usual and customary."

Defendants request that Plaintiff meet and confer to narrow the scope of this Request to ensure that it is not unduly burdensome to Defendants and that Plaintiff is able to get the information it is seeking.

Request No. 45:

Produce any and all Documents and/or Communications supporting, refuting, or relating to Your affirmative defenses identified in Your Answers to Fremont's First Set of Interrogatories to Defendants.

Response to Request No. 45:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiffs Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request is premature as the Defendants are not required to file an Answer to the Complaint yet and are thus not required to produce documents relating to their affirmative defenses at this time. Defendants further object that this Request seeks disclosure of information protected by the attorney work-product doctrine. Defendants will supplement this response within a reasonable time after filing their Answer to the Complaint

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Attorneys for Plaintiffs

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation,

Plaintiffs,

vs.

UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20,

Defendants.

Case No.: A-19-792978-B
Dept. No.: XXVII

PLAINTIFFS' OPPOSITION TO MOTION TO COMPEL PRODUCTION OF CLINICAL DOCUMENTS FOR THE AT-ISSUE CLAIMS AND DEFENSES AND TO COMPEL PLAINTIFF TO SUPPLEMENT THEIR NRCP 16.1 INITIAL DISCLOSURES ON AN ORDER SHORTENING TIME

Hearing Date: September 30, 2020
Hearing Time: 1:30 p.m.

Plaintiffs Fremont Emergency Services (Mandavia), Ltd. ("Fremont"); Team Physicians of Nevada-Mandavia, P.C. ("Team Physicians"); Crum, Stefanko and Jones, Ltd. dba Ruby Crest

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Emergency Medicine ("Ruby Crest" and collectively the "Health Care Providers") file this opposition to defendants UnitedHealth Group, Inc.; UnitedHealthcare Insurance Company; United HealthCare Services, Inc.; UMR, Inc.; Oxford Health Plans, Inc.; Sierra Health and Life Insurance Co., Inc.; Sierra Health-Care Options, Inc.; and Health Plan of Nevada, Inc.'s (collectively, "United") Motion to Compel Clinical Records (the "Motion").

This Opposition to the Motion ("Opposition") is based upon the record in this matter, the Declaration of Kristen T. Gallagher, the points and authorities that follow, the pleadings and papers on file in this action, and any argument of counsel entertained by the Court.

POINTS AND AUTHORITIES

I. INTRODUCTION

As a threshold issue, United did not adequately discharge its meet and confer obligations on this issue. Second, like its proposed email protocol, United's Motion is meant to distract and delay these proceedings by seeking underlying clinical records supporting claims that United already adjudicated and deemed allowable based on the Health Care Providers' submission of appropriate records. The Health Care Providers' First Amended Complaint makes clear that this case does not involve the "right to payment" and, in connection with the breach of implied contract and related claims, they only seek the proper reimbursement rate. This Court agrees with this landscape, a landscape that necessarily guides the scope of discovery and which dictates that clinical records are simply not relevant and proportional to the needs of a case that has nothing to do with "right to payment." June 24, 2020 Order Denying United's Motion to Dismiss at ¶ 5 ("On May 24, 2019, Fremont filed a Motion to Remand (ECF No. 5) on the basis that this case, which only involves questions of the proper rate of payment, and not the right to payment, is not completely preempted by ERISA.").

United does not hide the fact that its Motion is retaliatory in response to the Court's September 9, 2020 ruling compelling United to produce its claims files: "Defendants now seek a reciprocal and equivalent order from the Court…." Motion at 8:8-9. But United has already admitted it has clinical records in its possession (*see* **Exhibit 1**, Sandra Way Decl. at ¶ 5(d)) and paid the at-issue claims at the level it deemed allowable. The Court should decline to order

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duplicative materials. Moreover, United's attempt to secure duplicative information is violative of Nevada's claim practices statutes which required United to seek any additional information during the claims adjudication process and on a time-specific schedule which has long expired. Its failure to raise this type of issue prior to final adjudication of whether the claim was allowed constitutes a waiver of any right to challenge the CPT level.[1] United's attempt to circumvent the prompt pay statutes should be rejected.

II. OVERVIEW OF THE INSTANT DISPUTE

A. Facts Relevant to the Current Dispute

United's current effort to force production of clinical records is a red herring which is demonstrable by the fact that United has not identified or challenged a single at-issue claim based on the CPT code level. It is evident that United's desire for clinical records is a manufactured defense that has no factual support and also reveals that United pled its twenty-fourth affirmative defense[2] with no factual support. United's Motion signals its intent to embark on a fishing expedition because United accepted the HCFA Forms, did not ask for additional information, or if it did, was satisfied with the supplemental information, and deemed the claim allowable at the

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[1] Current Procedural Terminology (CPT) code is a medical code set maintained by the American Medical Association. The CPT codes for emergency departments services are 99281-99285. For example, CPT code 99285 provides:

> Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

[2] United's Twenty-Fourth affirmative defense states:

> Plaintiffs' claims are subject to setoff and/or recoupment with respect to claims for which United made payment on the basis of current procedural terminology ("CPT") or other billing codes included in Plaintiffs' submissions that Plaintiffs' clinical records of their patients' care reveal to have been improperly submitted, either because Plaintiffs' clinical records do not support submission of the codes at all, or because Plaintiffs' clinical records establish that different codes should have been submitted.

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level submitted. This is evident by United's payment, although at an arbitrary reimbursement rate. United's attempt to re-open the issue is a veritable "do-over" that is prohibited under Nevada law. Specifically, Nevada's prompt pay statutes required United to ask for additional information within 20 days of the Health Care Providers' submission of a HCFA Form. *See e.g.* NRS 683A.0879, 689A.410, 689B.255, 689C.485, 695C.185, NAC 686A.675. The Court can determine as a matter of law that United was ultimately satisfied with the Health Care Providers' submission because there is no dispute that United paid the at-issue claims based on the CPT code indicated:

> Answering paragraph 26 of the First Amended Complaint, ***United admits that health plans insured or administered by United have paid Plaintiffs for covered services*** on various claims with dates of service through July 31, 2019.
>
> Answering paragraph 193 of the First Amended Complaint, ***United admits*** that Plaintiffs have provided medical services to some participants in health plans insured or administered by United, ***and that health plans insured or administered by United have paid Plaintiffs for covered services***.
>
> Answering paragraph 194 of the First Amended Complaint, ***United admits*** that Plaintiffs have provided medical services to some participants in health plans insured or administered by United, and ***that health plans insured or administered by United have paid Plaintiffs for covered services***.
>
> Answering paragraph 196 of the First Amended Complaint, ***United admits that health plans insured or administered by United have paid Plaintiffs for covered services, typically directly.***

Answer ¶¶ 26, 193, 194, 196 (emphasis added). Indeed, the Provider Remittance Advice forms ("PRAs") that United generated and issued affirmatively state the CPT code United considered and deemed allowed in connection with the at-issue claims. *See, e.g.*, **Exhibit 2** (sample PRAs).

Further, United admits that when it paid each at-issue claim it was "based on the terms of the applicable health benefits plan documents specifying which medical services are covered, and, the amount of benefits the plan will pay ***for covered services.***" **Exhibit 3**, Answers to Interrogatories Nos. 6, 7. Thus, United has already deemed the at-issue claims "covered

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services."[3] To be clear, this dispute is specific to the allegations that United failed to pay the full amount of the claim, not that it denied claims based on the CPT code. This is not, as United contends, a case that requires the Health Care Providers to "prove that they actually performed the services for which they seek over $26 million dollars in additional reimbursements." Motion at 7:18-19. Indeed, United's adjudication of the claims, although at a manipulated reimbursement rates, negates the need for the Health Care Providers to "prove" the underlying services for each claim because United already considered and deemed these claims allowable.

B. The Relevant Meet and Confer Discussions

Fremont served its response to RFP No. 6 on July 29, 2019. **Exhibit 4**, Gallagher Decl. ¶ 3. Not until the end of January 2020 did United even mention Fremont's responses, the timing obviously related to the Health Care Providers' motion practice relating to United's discovery failures that was heard by the federal district court on February 12, 2020. *Id.* at ¶ 4. In advance of that hearing, on February 10, 2020, the Health Care Providers conveyed a discovery compromise to which United has still failed to substantively respond.[4] *Id.* at ¶ 5.

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[3] Further evidence that United has already deemed the at-issue claims allowable, is United's commercial reimbursement policy that uses its affiliate's Optum Emergency Department Claim (EDC) Analyzer, whose stated goal "is to achieve fair and consistent evaluation and management coding and reimbursement of facility outpatient emergency department claims. The EDC Analyzer™ systematically evaluates each ED visit level code in context of other claim data." (available at https://www.uhcprovider.com/en/policies-protocols/commercial-policies/commercial-reimbursement-policies.html).

[4] The proposal stated:

> In advance of Wednesday's hearing, below is a discovery proposal that would result in an expedited ability for the parties to agree on the health care claims data and would eliminate or greatly reduce the need for United to collect and produce provider remittance forms/provider EOBs except for where the parties identify a discrepancy in the billed amount or allowed amounts or as specified below. Similarly, it would eliminate or greatly reduce the need for Fremont to collect and produce HCFA forms and related billing documents. Please review and let me know in advance of Wednesday's hearing whether United will agree to the following:
>
> 1. The Health Care Providers have already produced a spreadsheet that includes member name and Defendants' claim no. (to the extent available in Health Care Providers' automated system), in addition to other fields:
> - Within 14 days, United provides matched spreadsheets and identifies any discrepancy in billed or allowed amounts fields;

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On February 13, 2020, the parties engaged in a meet and confer that included Fremont's response to RFP No. 6. *Id.* at ¶ 6. The Health Care Providers explained that it objected to the request because clinical records for the at-issue claims are not relevant to the First Amended Complaint's allegations and United had not raised an affirmative defense related to the amount that was billed or the applied CPT code, nor did United deny payment or otherwise challenge or deny the applied coding so the request does not inform the elements of the claims asserted. *Id.* Importantly, during the meet and confer, United's only stated basis for disagreeing with Fremont's objection was that it claimed clinical records are relevant to the reasonable value of services provided/unjust enrichment. *Id.* Not once during the meet and confer did United indicate that it disputed the CPT levels already deemed allowed and allowable. *Id.* Yet, this is now United's lead argument in the Motion. Nevertheless, United failed to reconvene prior to filing the Motion. *Id.* at ¶ 7. So although United asserts it was hoping to reach a reasonable compromise (Motion at 4:19-22), it never contacted the Health Care Providers between February 13, 2020 and the filing of the Motion, a period of over seven months. *Id.*

Nor does United make any mention of the fact that it has never engaged in meaningful discussions regarding the Health Care Providers' proposal aimed at streamlining document

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- Within 7 days thereafter, for claims upon which the billed and allowed data match, parties stipulate that there is no need for further production of EOBs and provider remittances for evidentiary purposes related to establishing the existence of the claim, services provided, amount billed by Health Care Providers and amount allowed by United.
- Approximately every quarter, this process will take place again with any new claims included in the Litigation Claims Spreadsheet that accrued after the previous spreadsheet was submitted.

2. United produces all EOBs/provider remittances for all Data iSight processed NV claims submitted by the Health Care Providers; and

3. United and the Health Care Providers respectively agree to provide a market file, i.e. a spreadsheet of payments from other payers (Health Care Providers) or a spreadsheet of payments to other providers (United) in the market which de-identifies the specific payer or provider, as applicable (for the time period 2016-Present). The parties agree to meet and confer promptly to agree on specified fields.

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retrieval and production.[5] *Id.* at ¶ 8. Instead United's Motion is an attempt to sow additional delay into these proceedings, to unnecessarily expand these proceedings and attempt an end run around United's court-ordered document production that United has declared includes clinical materials (Ex. 1, Sandra Way Decl. at ¶ 5(d) (although the Health Care Providers contend they are not relevant).

C. Relief Sought in Opposing the Motion

The Health Care Providers seek an order denying United's Motion to compel production of clinical records for the at-issue claims because the information is already in United's possession, United admitted it has evaluated the CPT level submitted and approved the applied code, the request is retaliatory and it is not relevant to the claims that form the First Amended Complaint. Nor is the request in furtherance of United's Twenty-Fourth affirmative defense because in the 17 months since commencement of this action, United has not identified a single at-issue claim that supports its assertion that any CPT level was incorrectly utilized on any of the at-issue claims.

III. LEGAL ARGUMENT

A. Legal Standard

United relies on an outdated version of NRCP 26(b)(1) in support of its Motion, claiming that the Court should compel production of clinical records because they are "relevant to the subject matter of the action." Motion at 10:3-4. The correct standard is:

> Parties may obtain discovery regarding any nonprivileged matter that is ***relevant to any party's claims or defenses and proportional to the needs of the case***, considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit.

[5] United also claims that the Health Care Providers should have produced EOBs and PRAs with their initial disclosures. This too is part of the compromise. Plus, these documents are United-generated. This shows United's intent to retaliate against the Health Care Providers' for the Court's recent order directing them to produce this very information.

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NRCP 26(b)(1). Thus, the Motion is faulty in that it does not provide the Court with an analysis of the correct standard applied to the requested documents. A review of the relevant factors demonstrates that United cannot meet this burden.

First, the clinical records are not relevant to the claims because United has already deemed the claims allowed and allowable at the CPT code submitted and later adjudicated. Answer ¶¶ 26, 193, 194, 196; Ex. 3, Answer to Interrogatory No. 6, 7.

Second, United's demand for clinical records does not meet the proportionality test: (a) the issue of rate of payment is the underpinning of this case and United already adjudicated the claims based on the CPT level identified in the PRAs created and issued by United -- this is not a right to payment case; (b) United already has access to the clinical records (Ex. 1, Way Decl. ¶ 5) and is trying to shift its burden under the Court's recent ruling that ordered United to promptly retrieve and produce the documents; (c) the parties' relative resources likely tips in United's favor as one of, if not the, largest health insurance company in the country and the clinical records are already in its possession or are readily accessible to United; (d) the clinical records are not important in this case as United has admitted it has adjudicated the claims at the CPT level indicated on PRAs; and (e) the burden and expense of producing clinical records is an exercise designed to exponentially expand these proceedings and delay resolution. The timing of this Motion makes this evident as Fremont served its responses to RFP No. 6 in July 2019, United did not take up the issue until January/February 2020 after the Health Care Providers pressed United on its failure to engage in discovery, United never discussed the new argument challenging coding of the at-issue claims during meet and confer efforts and has not identified a single purportedly offending claim, and United admits it seeks a reciprocal order after the Court found United has tried to block legitimate discovery.[6] **Exhibit 5**, September 9, 2020 Hrg. Tr. at

[6] Specifically, the Court found:

> First, what I find is that it is the defendant's effort to avoid a Motion to Compel on those discovery requests one thousand three hundred seventeen. It really just is an email protocol and not an ESI protocol. It's -- it would unreasonably hamper the Plaintiff from obtaining information with regard to identity of custodians and information that, I believe, will be discoverable. But -- so I'm going to deny the

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63:5-18. As a result, United's Motion fails to meet Rule 26(b)'s requirements and the Court should deny the Motion.

B. United's Request for Clinical Records is a Diversion

1. United's Attempt to Shift the Evidentiary Burden is Improper

Without any legal basis for seeking clinical records, United nevertheless tries to burden the Health Care Providers with production of documents that United already has (Ex. 1, Way Decl. ¶ 5) and has been ordered to produce. Further, and contrary to United's arguments in the Motion, the Health Care Providers do not have to rely on any clinical records to carry their burden because United already adjudicated the at-issue claims and made payments based on the HCFA Forms and information submitted to United at the time. In other words, United adjudicated the claim at the CPT code submitted, either did or did not ask for additional information and paid the claim, but not at the right reimbursement rate. This constitutes a clear waiver of this issue which occurs when a party knows of an existing right and either (1) actually intends to relinquish the right or (2) exhibits conduct so inconsistent with an intent to enforce the right as to induce a reasonable belief that the right has been relinquished. *Hudson v. Horseshoe Club Operating Co.*, 112 Nev. 446, 457, 916 P.2d 786, 792-93 (1996). United's attempt to resurrect these issues is also violative of Nevada law by requesting information already in United's possession and is time-barred under Nevada law. *See e.g.* NRS 683A.0879, 689A.410, 689B.255, 689C.485, 695C.185, NAC 686A.675. Had United rejected the claim based on the CPT code, it was required to do so at the time of adjudication. *Id.* Indeed the PRAs – documents created by United at the time it deemed each at-issue claim allowable – confirm that the CPT code was approved. *See, e.g.*, **Ex. 2** (PRA examples).

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motion, but I am going to order both parties to meet and confer with regard to a more comprehensive electronic discovery protocol and to report back at our continued hearing on the 30th.

It's not fair for the Plaintiff to determine those search terms and custodians before it has complete access to determine how to prioritize (indiscernible). The Plaintiff has the burden of proof here, and so I find that this was simply an effort to -- an unreasonable push to cutting off the Plaintiff from doing a meaningful discovery.

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United largely relies on a single unreported case – *Sacred Heart Health* – for the proposition that clinical records should be produced. *Sacred Heart Health System, Inc. v. Humana Military Healthcare Services, Inc.*, Case No. 3:07-cv-62/MCR/EMT (N.D. Fla. Oct. 21, 2011). The case is not analogous and provides no guidance. There, the network hospitals submitted claims for reimbursement of services provided to military family members and retirees through a government program. The claims were submitted on pre-approved forms using certain codes to identify the services provided. Motion, Ex. 7 at 3, 17. Further, the parties' contracts and governing federal regulations included post-payment audit parameters. *Id.* at 4. Thus, claims were submitted with basic information. It follows that post-payment audits were contractually in place to allow for review of claim accuracy and such audits were required under the relevant federal regulations. *Id.* at 17-18.

Sacred Heart is wholly distinguishable. First, United admits it has clinical records already. Ex. 1, Way Decl. ¶ 5. Second, there are no contractual post-audit procedures between United and the Health Care Providers. In fact, Nevada's prompt pay statutes prohibit an insurer from asking for documents it already has and United was required to promptly asked for information it needed to adjudicate the claim within 20 days after receiving the claim. NRS 683A.0879, 689A.410, 689B.255, 689C.485, 695C.185, NAC 686A.675. Third, as this Court may recall, the Health Care Providers are obligated to provide emergency services to anyone that presents to an emergency room, regardless of ability to pay. *See* Emergency Medical Treatment & Labor Act ("EMTALA"), 42 U.S.C. § 1395dd; *see also* NRS 695G.170(1);[7] 42

[7] NRS 695G.170 states, in part:

> As used in this section, "medically necessary emergency services" means health care services that are provided to an insured by a provider of health care after the sudden onset of a medical condition that manifests itself by symptoms of such sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in:
>
> (a) Serious jeopardy to the health of an insured;
>
> (b) Serious jeopardy to the health of an unborn child;
>
> (c) Serious impairment of a bodily function; or

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C.F.R. § 438.114(c)(1)(i). The "emergency services and care" required to be provided under Nevada law means:

> ***medical screening, examination and evaluation*** by a physician or, to the extent permitted by a specific statute, by a person under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment and surgery by a physician necessary to relieve or eliminate the emergency medical condition or active labor, within the capability of the hospital.

NRS 439B.410(5). By the time the Health Care Providers submitted the at-issue claims, United's members already satisfied the standard in NRS 439B.410(5) because they presented to an emergency department and sought care which necessarily included medical screening, examination and evaluation before any treatment was provided. Nevada law also precludes an insurer from requiring prior authorization for emergency services. NRS 695G.170. United reviewed and allowed for the emergency services at the level indicated on the United-generated PRAs. Ex. 5.

It cannot be overlooked that United does not dispute that at the core of this dispute is its failure to pay the right reimbursement amount, not that the level of severity of the emergency department visit at issue. To demonstrate something contrary, at the time of adjudication of the claim, United would have been required to demonstrate that its Member did not meet the requirements of NRS 695G.170 when the Member presented to one of the local emergency departments for treatment.

2. Clinical Records are Not Required to Establish the Reasonable Value of Services

Next, United maintains that the Health Care Providers' alternative claim for unjust enrichment requires them to re-establish the level of emergent care provided to its Members, i.e. what CPT code was billed and subsequently paid by United. This is an exercise that is unnecessary because the Health Care Providers already provided the emergency services provided, as they were required to do under federal and state law, and for which United is obligated to provide that coverage. NRS 695G.170.

(d) Serious dysfunction of any bodily organ or part.

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United twists the elements of an unjust enrichment claim and tries to reframe the evidentiary burden, arguing that the Health Care Providers have to establish the underlying "value of the good or services at issue," claiming that the "value" necessarily includes analyzing clinical records. This is not accurate because the cornerstone of the evaluation under Nevada law relates to market value. *Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. 371, 381 n.3, 283 P.3d 250, 257 n. 3 (2012) (citing Restatement (Third) of Restitution and Unjust Enrichment § 49(3)(c) & cmt. f (2011); *see also Massachusetts Eye and Ear Infirmary v. QLT Phototherapeutics, Inc.*, 552 F.3d 47, n.26 ((1st Cir. 2009), *decision clarified on denial of reh'g*, 559 F.3d 1 (1st Cir. 2009) (the fair market value of a requested benefit was a well-accepted measure of unjust enrichment). Or further, a previous agreement between the parties may be a proper consideration in determining the reasonable value of services rendered. *See Flamingo Realty, Inc. v. Midwest Dev., Inc.*, 110 Nev. 984, 988–89, 879 P.2d 69, 71–72 (1994) *see also Children's Hosp. Cent. California v. Blue Cross of California*, 172 Cal. Rptr. 3d 861, 872 (2014) (internal citations omitted) (the true marker of the "reasonable value" of services has been described as the "going rate" for the services or the "reasonable market value at the current market prices"); *Eagle v. Snyder*, 412 Pa. Super. 557, 604 A.2d 253 (1992) (reasonable value of medical services may be determined through expert testimony regarding the market value of the medical services provided based on the average charges in the region where the services were performed); Restatement (Third) of Restitution and Unjust Enrichment § 31 cmt. e (2011) ("Where such a contract exists, then, quantum meruit ensures the laborer receives the reasonable value, usually market price, for his services.").

The foregoing authorities demonstrate that United is just plain wrong that clinical records have to be reviewed in order for the Health Care Providers to prove a claim for unjust enrichment. Instead, the Health Care Providers will be able to introduce evidence that the Health Care Providers conferred a benefit on United through market data and similar evidence.[8] Here, the

[8]"A person confers a benefit upon another if he gives to the other possession of or some other interest in money, land, chattels, or choses in action, performs services beneficial to or at the request of the other, satisfies a debt or a duty of the other, or in any way adds to the other's

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Health Care Providers have submitted evidence of full billed charges and are in the process of responding to discovery that will provide (de-identified) market data. So far, United has refused to do the same. Thus, in terms of unjust enrichment or quantum meruit claims that require proof of the reasonable value of services, the underlying clinical records are not part of that analysis.

United's reliance on *Howell v. Hamilton Meats & Provisions*, Inc., 52 Cal. 4th 541, 566, 257 P.3d 1130, 1144 (2011) is misplaced. *Howell* concerned the collateral source rule and whether a plaintiff in a personal injury case was entitled to recover more than the providers' negotiated rates with an insurer. The court announced a rule holding a "plaintiff may not recover as past medical damages the amount of a negotiated rate differential" because a plaintiff "does not incur liability in the amount of the negotiated rate differential, which also is not paid to or on behalf of the plaintiff to cover the expenses of the plaintiff's injuries, it simply does not come within the rule." *Id.* at 565, 257 P.3d at 1144-1145. Thus, when the *Howell* court stated that a billed price is not necessarily representative of the cost of providing services, the context is that the plaintiff was not entitled to recover past damages that exceeded the amount the provider agreed to accept. Thus, *Howell* – a case dealing with the collateral source rule and whether an injured plaintiff can recover damages in excess of a provider/insurer negotiated rate – says nothing about requiring any health care provider to re-submit clinical records that were already deemed allowed.

United also tries to frame the at-issue claims as listed on an "unverified Claims Spreadsheet." Motion at 15:17-18. This is a signal that United does not intend to meaningfully participate in trying to streamline the actual issues in this case. The Health Care Providers have provided a list of at-issue claims (FESM000344) and invited United to identify data points that are not consistent. For those that match with United's data, there is no dispute that the claim is what the Health Care Providers have asserted. United has not engaged in this exercise – seemingly so they can continue to hold up this litigation and unnecessarily create work where

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security or advantage." Restatement (First) of Restitution §1 cmt. b. (1937); *see also Certified Fire Prot. Inc.*, 128 Nev. at 382, 283 P.3d at 257 ("'[B]enefit' in the unjust enrichment context can include 'services beneficial to or at the request of the other,' 'denotes any form of advantage,' and is not confined to retention of money or property").

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none should be required. After all, this is a dispute about the amount United paid, its self-declared intent to unilaterally reduce reimbursement with the help of third-parties.

3. United's Admissions Bar a Recoupment/Setoff Affirmative Defense

United also contends that it should be permitted to pursue a claim for recoupment and/or offset. "Recoupment is an affirmative defense to a contract permitting a breaching party to offset damages to the extent the plaintiff has also breached. *See Schettler v. RalRon Capital Corp.*, 275 P.3d 933, 941 (Nev. 2012). The defense is not applicable to any claim sounding in tort. *Id.*; *F.D.I.C. v. Jacobs*, No. 3:13-cv-00084-RCJ, 2014 WL 132463, at *2 (D. Nev. Jan. 10, 2014) Recoupment must arise out of the same transaction and involve the same parties; thus, ***it does not apply when the defendant's allegations arise out of a transaction "extrinsic to the plaintiff's cause of action."*** *Id.*; *see also bOlduc v. bEal bAnk, sSB*, 167 F.3D 667, 672 n. 4 (1st Cir. 1999).[9]

Here, United's recoupment defense is barred not only because United already adjudicated the claims and Nevada law prohibits further demand for documents already in United's possession, but it is barred as a matter of law because the right of payment (i.e. whether a claim is allowable) is a separate consideration from how much United decided to pay once the claim is deemed allowable. Given United's confirmation that it deemed the at-issue claims allowable, its attempt at recoupment must be stricken. Further, on its face, United's Twenty-Fifth affirmative defense makes no reference to clinical records whatsoever and simply states that the "billed charges exceeded the billed charges submitted to other payors…" Motion at 16: 11-16. There is nothing that triggers any need to review clinical records.

Similarly, United argues that its experts will need clinical records for market analyses and "coding trend analyses," but CPT level trends has nothing to do with the amount United

[9] Additionally, while the defendant may thus defend against the plaintiff's claim by asserting competing rights arising out of the same transaction and thereby extinguish or reduce any judgment awarded to the plaintiff, recoupment "does not allow the defendant to pursue damages in excess of the plaintiff's judgment award." *Nevada State Bank v. Jamison Partnership*, 106 Nev. 792, 797 n. 2, 801 P.2d 1377, 1381 n. 2 (1990).

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should have paid for the at-issue claims it already determined were allowed based on the CPT codes submitted. The Court should reject United's argument.

4. The Health Care Providers Were Not Obligated to Produce Clinical Records with NRCP 16.1 Initial Disclosures

United's contention that the Health Care Providers should have produced clinical records with its initial disclosures in October 2019 is unfounded. United did not serve an Answer to any pleading until July 8, 2020 and during a meet and confer in February 2020, United's only stated basis for disagreeing with Fremont's objection was that it claimed clinical records are relevant to the reasonable value of services provided/unjust enrichment. Ex. 4 at ¶ 6. Not once during the meet and confer did United indicate that it disputed the CPT levels already deemed allowable. *Id.* Therefore, there is nothing that obligated the Health Care Providers to disclose underlying clinical records – documents that United represents it already has.[10]

IV. CONCLUSION

Based on the foregoing, the Health Care Providers respectfully request that the Court deny United's Motion in full.

DATED this 29th day of September, 2020.

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By: */s/ Kristen T. Gallagher*

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[10] It should also be noted that, not once, during the February 13, 2020 meet and confer, did United assert that the Health Care Providers had an obligation to produce clinical records as a part of its initial disclosures. Ex. 4 at ¶ 6.

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 29th day of September, 2020, I caused a true and correct copy of the foregoing **PLAINTIFFS' OPPOSITION TO MOTION TO COMPEL PRODUCTION OF CLINICAL DOCUMENTS FOR THE AT-ISSUE CLAIMS AND DEFENSES AND TO COMPEL PLAINTIFF TO SUPPLEMENT THEIR NRCP 16.1 INITIAL DISCLOSURES ON AN ORDER SHORTENING TIME** to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

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EXHIBIT 1

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EXHIBIT 1

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UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation

Plaintiff,

vs.

UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC. dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC. dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada

Case No.: 2:19-cv-00832-JCM-VCF

DECLARATION OF SANDRA WAY IN SUPPORT OF DEFENDANTS' OBJECTIONS TO FREMONT'S REQUESTS FOR PRODUCTION, INTERROGATORIES AND REQUESTS FOR ADMISSIONS

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corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20,

Defendants.

I, Sandra Way, declare under penalty of perjury that the foregoing is true and correct:

1. I am employed as the Claim & Appeal Regulatory Adherence Business Manager for United Healthcare Employer & Individual. I have worked for United for 10 years. My job responsibilities include providing oversight of regulatory related functions for E&I Claim & Appeal Operations.

2. I understand that, according to Fremont, there are approximately 15,210 claims at issue in this litigation which are identified in a spreadsheet produced by Fremont that is bates numbered FESM000011.

3. For each of the claims at issue, I understand that Fremont has submitted written discovery requests to Defendants, including requests for production, interrogatories and requests for admissions. While each request often asks for a slightly different piece of information related to the claims, taken together, the requests ask for any and all information related to the claims at issue, including all documents and communications related to the claims.

4. Many of Fremont's requests essentially ask for information that collectively constitutes what is often called the "administrative record" for each claim.

5. To produce the administrative record for each claim, United must locate and produce the following categories of documents from their records for each individual claim, to the extent that any such documents exist:

a. Member Explanations of Benefits ("EOBs");

b. Provider EOBs and/or Provider Remittance Advices ("PRAs");

c. Appeals documents;

d. Any other documents comprising the administrative records, such as correspondence or clinical records submitted by Plaintiffs;

e. The plan documents in effect at the time of service.

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6. These documents are not stored together and are spread across at least four separate systems within United.

7. The documents from categories *a*; and *b*, are stored on a United electronic storage platform known as EDSS. "EDSS" stands for Enterprise Data Storage System. The documents from category *d* may be stored in another United electronic storage platform known as IDRS. "IDRS" stands for Image Document Retrieval System. When using EDSS or IDRS, documents must be individually searched for and pulled. The process for doing so looks like this:

First, a United employee must access EDSS or IDRS from their computer.

Second, the employee must select the type of document that they wish to pull from a drop down menu: claim form, letter, EOB, etc.

Third, the employee must run a query for that document for each individual claim at issue, based on some combination of claim identifying information (e.g., the claim number, member ID number, dates of services, social security number, provider tax identification number, etc.).

Fourth, the employee must download the documents returned by their query.

Fifth, the employee must open and review the downloaded documents to confirm that they pertain to one of the at-issue claims.

Sixth, if the documents do pertain to an at-issue claim, the employee must migrate those documents to a United shared drive specific to this litigation, from which the documents will be transferred to United's outside counsel for this matter.

8. Documents from category *c* are located on a United electronic escalation tracking platform known as ETS. "ETS" stands for Escalation Tracking System. Pulling documents from ETS, which is done on an individual claim-by-claim basis, substantially mirrors the process for pulling documents from EDSS and IDRS.

9. My team has previously pulled documents from categories *a*, *b*, *c*, and *d* in connection with other provider-initiated litigation. Based on the documents that we pulled previously, we have developed estimates of the average time that it takes to pull each category of document:

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a. Member Explanations of Benefits ("EOBs"): ***45 minutes.***[1]

b. Provider EOBs and/or Provider Remittance Advice ("PRAs"); ***20 minutes.***

c. Appeals documents: ***30 minutes.***

d. Other documents comprising the administrative records: ***15 minutes.***

10. I understand that Plaintiffs in this case have questioned the above time estimates, based on their very different experience accessing PRAs, claiming that it only takes Plaintiffs two minutes to pull a PRA from the UHC Portal for providers. These are completely different enterprises, and it is to be expected that it would take substantially less time for a provider to access their own, pre-sorted records through the UHC Portal, than it would for United to (1) search for and locate the records of health plan members based on varying pieces of data, (2) verify that the located records are the correct ones, and further contain no extraneous material, in accordance with United's rigorous standards for ensuring that HIPAA-protected information is not improperly disclosed, and (3) process that information for external production in accordance with United's prescribed process for court-ordered discovery production. My estimates are based on substantial experience locating, verifying, and processing records for many hundreds of discovery productions. I stand by them, and stand ready as necessary to provide supporting testimony under oath.

11. By way of example, as stated above, it takes 45 minutes on average to locate, verify, and process a member EOB. Allow me to explain.

a. United stores EOBs as images that are stored in EDSS and marked with "Film Locator Numbers" or "FLNs".

b. To locate the correct EOB for a given claim, we must first determine the correct FLN by running queries in the system based on the data given to us by the provider. This process can take substantial time, because United-administered plans have tens of millions of members, each of whom is likely to see multiple

[1] Searching member EOBs is more time consuming than searching provider EOBs/PRAs due to the volume of United members and member records.

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providers on multiple dates of service, and even a single date of service can result in the generation of numerous EOBs. Moreover, if we are required to rely on member name and date of service information to identify the correct records, United typically has numerous members with the same or similar names that need to be sorted through to determine a match. In addition, this process is further complicated by the fact that the data given to us by providers in litigation frequently contains nicknames or misspellings of names—and sometimes transposed digits and other inaccuracies—that does not match our systems data and significantly complicates the process.

c. Once we use the claim data that is furnished to us by the provider to identify what we believe to be the correct FLN, we must then enter that FLN into EDSS to pull up and download the EOB in question.

d. Once the targeted EOB has completed downloading, our rigorous HIPAA protection protocol requires us to review the entire downloaded document to ensure (1) that it is the correct EOB that matches the claim at issue in the litigation and (2) that there are no extraneous pages included that might result in the inadvertent but unauthorized disclosure of HIPAA–protected information. Some EOB records are simple, but others may contain several pages, and the process of confirming a match and confirming that no extraneous information is included takes substantial time.

e. Once the EOB has been verified, we must take the additional step of processing and uploading it to the specific share drive that has been established for the particular instance of litigation.

12. For each individual EOB, the above-described process may take more or less than 45 minutes, but across a large volume of records, my experience confirms that 45 minutes is the average. As set forth in paragraph 9 above, EOBs take the longest time to locate, verify, and process because of the massive volume of member records and the difficulties that are typically encountered using member data to locate the requested records. Similar processes govern the

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location, verification, and processing of the other records identified in Paragraph 9, however, and the completion of those processes typically takes meaningful time.

13. Thus, I estimate that it will take, on average, about ***2 hours*** to pull a full set of the ***a***, ***b***, ***c***, and ***d*** category documents for a single claim, which would need to be done for each of the 15,210 claims at issue claim (for a total of approximately ***30,420 hours***). Based on the forgoing time estimates, it would take a team of four people working full-time on nothing other than gathering documents for this case over ***3 years*** to pull the documents related to categories ***a***, ***b***, ***c***, and ***d***. This does not account for other factors that could complicate the collection process, such as any at-issue claims that have not been successfully "mapped" to a unique United claim number,[2] or archived documents that may have to be located and pulled from other sources or platforms.

14. If a provider includes an accurate Claim Number and Member Number in their claim data, the average time listed above for identifying EOBs can be substantially shortened. That is because accurate Claim Number and Member Number information avoids the need to search through multiple duplicative member names and multiple and frequently overlapping dates of service to identify the specific claim at issue. I estimate that having accurate Claim Number and Member Number information would reduce the time it typically takes to locate, verify, and process an EOB from 45 minutes to 30 minutes, and the time that it would take to pull all of the documents described in Paragraph 9 from 2 hours to 1.5 hours. Based on my review of Fremont's list of claims (FESM000011), Fremont appears to have provided some, but not all of the claim numbers and member numbers for the claims it is seeking information on. I have not yet been able to verify the accuracy of these numbers.

15. My group does not handle documents from category ***e*** and I do not have personal knowledge of the processes utilized to locate and pull plan documents. Nonetheless I have been informed of the relevant processes by colleagues whose job functions do include locating and

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[2] Lack of a valid United claim number can make searching for many of the document categories described much more time consuming and complicated. In some instances, it can also make it impossible to identify and collect the right documents.

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pulling these documents. I understand that plan documents for ***current*** United clients can be accessed through a United database. First, the team must access the appropriate database, locate, and pull all of the relevant documents for each plan implicated by the at-issue claims. Once pulled, a United employee must then open each document, confirm that the document relates to the plan covering the at-issue claim, label the file, and migrate the document to the appropriate shared drive location related to this litigation. The colleagues who have informed me have previously pulled plan documents in connection with other provider-initiated litigation where only 500 claims were at issue. Based on the documents that they pulled previously and the 15,210 claims at issue here, it is estimated that it will take approximately ***6,996 hours*** to collect the relevant plan documents. Because plan documents will be handled by a team that is separate from my team handling the claim and appeal document collection, this time estimate will run concurrently to the time estimate for pulling documents pertain only to pulling documents related to categories ***a***, ***b***, ***c***, and ***d***.

16. The above time estimates for plan documents pertain only to pulling documents related to ***current*** United clients. Documents related to former clients may be far more difficult and time consuming to access. I understand that archived plan documents may be located in off-site storage. In other instances, I understand that these archived documents may be stored in legacy systems that use outdated file formats that are not readable on today's computers; in these instances the documents would need to be converted to PDFs before a United employee can even verify whether the document is relevant to this litigation. We do not currently know how many of the at-issue claims will require accessing archived documents.

17. The above statements regarding the estimated amount of time to locate and produce documents that are responsive to certain of Fremont's written discovery requests apply to documents in the possession of the United Health Defendants (United HealthGroup, Inc., United Healthcare Insurance Company, and United Health Care Services, Inc.), the Sierra Defendants (Sierra Health and Life Insurance Company, Inc., Sierra Health-Care Options, Inc., and Health Plan of Nevada, Inc.) and Defendant UMR, Inc. In regard to the United Health Defendants, I have personal knowledge of the processes utilized to locate and pull claim

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documents except in regard to category *e*, as previously discussed in paragraph 15 of this Declaration. In regard to the Sierra Defendants and UMR, Inc., I do not have personal knowledge of the processes utilized to locate and pull claim documents. Nonetheless I have been informed of the relevant processes for the Sierra Defendants and UMR, Inc. by colleagues whose job functions do include locating and pulling these documents. I understand that the process utilized by the Sierra Defendants and UMR, Inc. to locate and pull the documents described in paragraph 5 of this Declaration is substantially similar to the process utilized by the United Health Defendants. I further understand that, just as with the documents that are in the possession of the United Health Defendants, it takes the Sierra Defendants and UMR, Inc. approximately 2 hours of time to locate and pull the administrative record for a claim.

18. I declare under penalty of perjury that the foregoing is true and correct.

Executed on January 29th, 2020 in Moline, Illinois

SANDRA WAY
Business Manager
Claim & Appeal Regulatory Adherence
United Healthcare

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EXHIBIT 2

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EXHIBIT 2

[redacted]

[redacted]

United HealthCare Services, Inc.
GREENSBORO SERVICE CENTER
P.O. BOX 30555
SALT LAKE CITY UT 84130-0555
PHONE: 1-877-842-3210

STD - PRA

UnitedHealthcare

PROVIDER REMITTANCE ADVICE

CRUM STEFANKO AND JONES LTD
RUBY CREST EMERGENCY MEDICINE
RUBY CREST EMERGENCY MEDICINE
PO BOX 638757
CINCINNATI OH 45263

PAYMENT DATE: [redacted]
TIN:
NPI:
PAYEE NAME: CRUM STEFANKO AND JONES LTD
PAYMENT NUMBER: [redacted]
PAYMENT AMOUNT:
GROUP NUMBER:
GROUP NAME:

PATIENT: [redacted]

SUBSCRIBER ID: [redacted]
CLAIM DATE:
REND PROV ID:

SUBSCRIBER NAME: [redacted]
DATE RECEIVED:
REND PROV: RUBY CREST EMERGENCY

CLAIM NUMBER: [redacted]
PRODUCT:

PATIENT CONTROL NUMBER	PATIENT ID	AUTH/REF NUMBER	DRG	DRG WEIGHT	CLAIM CHARGE AMOUNT	CLM ADJ AMT	GRP CD	CLM ADJ RSN CD	CLAIM PAYMENT AMOUNT	PATIENT RESPONSIBILITY
[redacted]					$1,404.00				$0.00	$479.20

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SERVICE LINE DETAIL(S)

LINE CTRL#	DATES OF SERVICE	SUB PROD/ SVC/ MOD	ADJ PROD/ SVC	MOD	REV	UNITS	ADJ QTY	CHARGE	AMOUNT ALLOWED	ADJ AMOUNT	GRP CD	CLM ADJ RSN CD	PAYMENT AMOUNT	REMARK/ NOTES
324304116 4Z1	01/05/19 - 01/05/19		99285			1		$1,360.00	$435.20	$924.80	PI	242	$0.00	IS
										$435.20	PR	1		
[redacted]														
CLAIM# [redacted]							SUBTOTAL	[redacted]						

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PAYMENT OF BENEFITS HAS BEEN MADE IN ACCORDANCE WITH THE TERMS OF THE MANAGED CARE SYSTEM.

NOTES

PI242	PAYER INITIATED REDUCTIONS - SERVICES NOT PROVIDED BY NETWORK/PRIMARY CARE PROVIDERS .
PR1	PATIENT RESPONSIBILITY - DEDUCTIBLE AMOUNT
PR234	PATIENT RESPONSIBILITY - THIS PROCEDURE IS NOT PAID SEPARATELY.
I4	THIS SERVICE OR SUPPLY IS DENIED. IT IS CONSIDERED PART OF ANOTHER SERVICE PERFORMED ON THE SAME DAY, OR IT IS NOT ALLOWED AS A SEPARATE CHARGE.
IS	MEMBER: THIS SERVICE WAS RENDERED BY AN OUT-OF-NETWORK PROVIDER AND PROCESSED USING YOUR NETWORK BENEFITS. IF YOU'RE ASKED TO PAY MORE THAN THE DEDUCTIBLE, COPAY AND COINSURANCE AMOUNTS SHOWN, PLEASE CALL DATA ISIGHT AT 866-835-4022 OR VISIT DATAISIGHT.COM . THEY WILL WORK WITH THE PROVIDER ON YOUR BEHALF. PROVIDER: THIS SERVICE HAS BEEN REIMBURSED USING DATA ISIGHT, WHICH UTILIZES COST DATA IF AVAILABLE (FACILITIES) OR PAID DATA (PROFESSIONALS). PLEASE DO NOT BILL THE PATIENT ABOVE THE AMOUNT OF DEDUCTIBLE, COPAY AND COINSURANCE APPLIED TO THIS SERVICE. IF YOU HAVE QUESTIONS ABOUT THE REIMBURSEMENT CONTACT DATA ISIGHT.
M80	NOT COVERED WHEN PERFORMED DURING THE SAME SESSION/DATE AS A PREVIOUSLY PROCESSED SERVICE FOR THE PATIENT.

THE MEMBER, PROVIDER, OR AN AUTHORIZED REPRESENTATIVE MAY REQUEST RECONSIDERATION OR APPEAL THE DECISION BY SUBMITTING COMMENTS, DOCUMENTS OR OTHER INFORMATION TO UNITEDHEALTHCARE. NETWORK PROVIDERS SHOULD REFER TO THE ADMINISTRATIVE GUIDE FOR CLAIM RECONSIDERATION OR APPEAL INFORMATION. IF YOU ARE A NETWORK PROVIDER APPEALING A CLINICAL OR COVERAGE DETERMINATION ON BEHALF OF