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Attorney for Plaintiff
SAN JOSE NEUROSPINE

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF VENTURA – HALL OF JUSTICE

SAN JOSE NEUROSPINE, Plaintiff, vs. KAISER FOUNDATION HEALTH PLAN, INC.; and DOES 1 through 20, inclusive, Defendants,	CASE NO.: **COMPLAINT** **1. Breach of Health and Safety §§ 1371.4 et seq** **2. Breach of Implied Contract** **3. Breach of Implied Covenant of Good Faith and Fair Dealing** **4. Unjust Enrichment** **5. Unfair Business Practices** **6. Quantum Meruit** **7. Recovery of Payment for Services Rendered**

PARTIES

1. Plaintiff SAN JOSE NEUROSPINE ("SJN") is a California corporation organized and existing pursuant to the laws of the State of California. SJN renders emergency services and care to patients as defined under Health and Safety Code ("H&S") § 1317.1(a)(1) within an emergency department capable facility licensed by the state department as defined under H&S §§ 1317.1(h) and 1317.1(d).

2. Defendant KAISER FOUNDATION HEALTH PLAN, INC., ("Kaiser") is a for-profit corporation which is licensed to conduct business, and does conduct business, in California.

3. SJN is unaware of the true names and capacities, whether corporate, associate, individual, partnership or otherwise of defendants Does 1 through 20, inclusive, and therefore sues such defendants by such fictitious names. SJN will seek leave of the Court to amend this complaint to allege their true names and capacities when ascertained.

4. Kaiser and Does 1 through 20, inclusive, shall be collectively referred to as "Kaiser" or

Defendants.

5. Patients "C.P.", "J.T.", "M.C.", and "Y.K." shall be referred to as "patients."

6. SJN has limited the disclosure of patient identification information pursuant to the privacy provisions of the federal Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. §§ 1320(d) *et seq.*, and the California Constitution, art. 1, § 1.

7. Defendants, and each of them, at all relevant times, have transacted business in the State of California. The violations alleged within this complaint have been and are being carried out in the State of California.

8. At all relevant times each of the defendants, including the defendants named "Doe," was and is the agent, employee, employer, joint venturer, representative, alter ego, subsidiary, and/or partner of one or more of the other defendants, and was, in performing the acts complained of herein, acting within the scope of such agency, employment, joint venture, or partnership authority, and/or is in some other way responsible for the acts of one or more of the other defendants.

GENERAL ALLEGATIONS

9. This action arises out of Kaiser's unjustified failure to pay $542,000 for medical services provided by SJN to four (4) patients insured by Kaiser.

10. After rendering highly skilled and valuable emergency medical services to patients insured by Kaiser, SJN submitted valid claims for reimbursement to Kaiser, for which Kaiser was obligated.

11. Kaiser has withheld all reimbursements without justification and has been unjustly enriched.

12. Kaiser's pattern of fraudulent behavior and unjustified refusal to reimburse SJN renders all potential administrative remedies futile.

13. SJN is Board Certified by the American Board of Neurological Surgery and is a Fellow of the American Association of Neurological Surgeons. SJN specializes in minimally invasive emergency spine surgery.

14. SJN provides emergency medical services to patients insured by various health insurance companies, including Kaiser.

15. The value of these medical services and the amount due to SJN is $542,000. Kaiser has reimbursed SJN for $67,057.99 of the total amount, leaving an unpaid balance of $474,942.01 due to

SJN.

16. The services rendered by SJN were induced by Kaiser's promise to make payments on behalf of its insured patients, on Kaiser's prior course of dealing and California law.

17. SJN submitted valid claims for reimbursement to Kaiser in a timely manner. At all times, SJN conformed its billing and claim procedures to Kaiser's requirements.

18. During the 2015-2016 billing cycle, SJN was in regular communications with claims representatives and billing department representatives at Kaiser. During this time, Kaiser began a series of unlawful, unfair, and/or fraudulent business practices intended to avoid repayment of the full amount owed to SJN.

19. By its unlawful, unfair, and/or fraudulent business practices, Kaiser intended to minimize its costs of paying reimbursement claims to SJN in order to maximize profits.

20. "In-network" providers with Kaiser with respect to insurance plans agree to accept discounted reimbursement rates in exchange for the benefits of network status, which include increased business, advertisements, and lower co-payments and deductibles for members. Conversely, out-of-network providers receive less plan business, but they are entitled to receive payment based on their charges for services rendered without any discount. Plaintiff is informed and believes that the Defendants punish out-of-network providers by underpaying them for the medically necessary, covered services they provide to Kaiser insured individuals.

21. Kaiser's unlawful, unfair, and/or fraudulent attempts, through the guise of billing formalities and oppressive delays, to deprive SJN of the amounts rightfully due ignore the reality that SJN rendered valuable medical services to Kaiser's insured in the amount of $542,000.

22. Kaiser deliberately and unjustifiably failed to adopt and implement reasonable standards for the prompt processing of SJN's claims knowing that such action would cause severe financial hardship to SJN.

23. Kaiser continues to withhold the $474,942.01 balance owed to SJN and refuses to make payment.

24. Kaiser's oppressive collection tactics have interfered with SJN's patient relationships and have substantially harmed SJN's reputation and ability to conduct business.

25. Plaintiff followed the same process for each and every claim in the lawsuit as described below.

26. Plaintiff relied upon the information provided by Defendants during the verification process, including representations from Defendants that Plaintiff was to be reimbursed at the usual and customary rate for the medical services provided.

27. After medical services were performed, Plaintiff properly and timely submitted claims through Defendants' designated claims handling channels. Defendants either denied the claims outright or drastically underpaid the claims.

28. After Defendants either denied or underpaid the claims, Plaintiff properly and timely appealed the non-payment and underpayment of the claims through Defendants' designated appeals channels. Defendants denied each and every appeal for each and every claim at issue in this lawsuit thereby exhausting Plaintiff's administrative remedies. Defendants either provided no explanations for their adverse determinations against Plaintiff or provided conclusory explanations that frequently consisted of one to two sentences.

29. Plaintiff billed $542,000 which is the usual and customary rate for the particular medical services in and around the surrounding counties. Defendants paid a mere $67,057.99, which is 12% of the amount billed for the services rendered.

30. Payment of 12% of the usual and customary rates for same or similar medical services rendered is dramatically lower than any other of the Plaintiff's insurance payors, including UnitedHealthcare, Cigna, and Aetna, and is tantamount to no payment at all.

31. Moreover, based on information and belief, payment of 12% of the usual and customary rates for same or similar medical services rendered is drastically lower than any other recognizable third party commercial or even government payor in the larger health care industry, including United, Cigna, Aetna and Medicare. Significantly, patient's pay higher premiums, at times substantially higher premiums, so that they may receive emergency medical treatment from the provider of their choice, including from out-of-network providers. They bargain for and expect that payment be made at the providers' usual and customary rates. In Plaintiff's experience, the payment of merely twelve cents on the dollar for the rendering of emergency medical treatment is unconscionable.

32. By authorizing SJN to provide services to Defendants' insured members, Defendants entered

into implied contracts with SJN whereby Defendants agreed to pay Plaintiff as a non-participating provider at Plaintiff's usual, customary and reasonable billed rates. Defendants have failed to pay these claims correctly under the implied contracts, by improperly paying claims at rates far below usual, reasonable and customary charges and far below the billed charges submitted by Plaintiff.

33. SJN admitted patients and during that stay, SJN rendered medically necessary care to patients.

34. SJN's usual and customary total billed charges for rendering the medically necessary care to patients amounted to $542,000.

35. Because SJN and Kaiser did not have a contract applicable to its members, SJN is entitled to SJN's usual and customary total billed charges for the medical services rendered to patients. The usual and customary total billed charges were $542,000.

36. SJN submitted the final bill regarding SJN patients to Kaiser for payment by Kaiser, which bill reflected SJN's usual and customary total billed charges.

37. Kaiser paid SJN a total of $67,603.68 as payment for the medically necessary care rendered to Kaiser patients.

38. However, Kaiser failed to pay SJN for the remaining balance of $474,942.01 for the medically necessary care rendered to SJN patients, despite demands thereof ("Amount Due").

39. SJN is informed and believes that there are a number of inherent flaws in Defendant's database which make that database invalid and inappropriate for setting usual, customary and reasonable rates. Among other flaws, the Defendant's database:

a. Does not determine the numbers or types of providers in any geographic area;

b. Does not determine the actual types of procedures performed within a geographic area;

c. Collects charge data which is not representative of the actual number of procedures performed within a geographic area;

d. Does not collect sufficient data to enable its users to determine whether the data reflects the charges of providers with any particular degree of expertise or specialization;

e. Does not collect sufficient provider-specific data to enable its users to determine whether the charges are from one provider, from several providers, or from only a minority subset of the providers in a geographic area;

f. Fails to compare providers of the same or similar training and experience level and, instead, combines and averages all provider charges by procedure code without separating the charges of physicians and non-physicians;

g. Does not collect patient specific information such as age or medical history or condition;

h. Does not ascertain the most common charge for the same service or comparable service or supply;

i. Does not determine the place of service or type of facility;

j. Does not collect sufficient data to enable it or its users to determine an appropriate medical market for comparing like charges;

k. Combines zip codes inappropriately, and uses zip codes instead of appropriate medical markets;

l. Fails to compare procedures that use the same or similar resources (and other costs) to the provider but, rather, indiscriminately combines all provider charges by procedure code without regard to such factors;

m. Fails to compare procedures of the same or similar complexity by, among other things, failing to record or account for CPT code modifiers;

n. Does not use appropriate statistical methodology;

o. Does not properly consider charging protocols and billing practices generally accepted by the medical community or specialty groups;

p. Does not properly consider medical costs in setting geographic areas;

q. Lacks quality control, such as basic auditing, to ensure the validity, completeness, representativeness, and authenticity of the data submitted;

r. Is subject to pre-editing by data contributors;

s. Reports charges that are systematically skewed downward;

t. Uses relative values and conversion factors to derive inappropriate usual, customary and reasonable amounts;

u. Uses a methodology that does not comply with contractual definition of usual, customary and reasonable; and

f. Fails to compare providers of the same or similar training and experience level and, instead, combines and averages all provider charges by procedure code without separating the charges of physicians and non-physicians;

g. Does not collect patient specific information such as age or medical history or condition;

h. Does not ascertain the most common charge for the same service or comparable service or supply;

i. Does not determine the place of service or type of facility;

j. Does not collect sufficient data to enable it or its users to determine an appropriate medical market for comparing like charges;

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p. Does not properly consider medical costs in setting geographic areas;

q. Lacks quality control, such as basic auditing, to ensure the validity, completeness, representativeness, and authenticity of the data submitted;

r. Is subject to pre-editing by data contributors;

s. Reports charges that are systematically skewed downward;

t. Uses relative values and conversion factors to derive inappropriate usual, customary and reasonable amounts;

u. Uses a methodology that does not comply with contractual definition of usual, customary and reasonable; and

v. Purports to be confidential and/or proprietary, which prevents access to, and scrutiny of, the data.

40. FEHBA and ERISA: Plaintiff's claims do not arise under 29 U.S.C. §§ 1001, *et seq.*, the Employment Retirement Income Security Act ("ERISA") or Federal Employees Health Benefits Acts ("FEHBA"). Plaintiff's claims are not based on the terms of the patient's plan. Plaintiff's claims are based on state law that regulate insurance and are not based on "benefits" as defined by 29 U.S.C. §§ 1001, *et seq.*, of ERISA. *Marin General v. Modesto & Empire Traction Co.*, 581 F.3rd 941 (9th Cir. 2009); *Cedars-Sinai Medical Center v. National League of Postmasters of the United States*, 497 F.3d 972 (9th Cir. 2007).

41. Tolling: All of the below patients went through an appeal process during which the statute was tolled in the interests of the parties resolving the claims themselves.

FIRST CAUSE OF ACTION

(BREACH OF HEALTH AND SAFETY CODE §§ 1371.4, *ET SEQ.*)

42. SJN incorporates by reference and re-alleges paragraphs above as though set forth in full.

43. As stated above, on or about the times described above, the patients described above were admitted through the emergency room for emergency services and care. SJN provided medically necessary emergency services to the patients described above from the time of their admission through the time the emergency services rendered resulted in stabilization of patients described above.

44. Furthermore, at all relevant times, the patients described above were members of a Kaiser health plan.

45. The total billed charges for the medically necessary emergency services rendered to the patients described above for the duration of the hospitalization period totaled $542,000, which was submitted to Kaiser.

46. Kaiser only paid $67,067.99 to SJN for the medically necessary emergency services provided to the patients described above.

47. Kaiser violated the California Health and Safety Code § 1371.4 by failing to reimburse SJN for the emergency services, supplies, and/or equipment provided to the patients described above until such emergency services resulted in stabilization of the patients described above, who were Kaiser

beneficiaries.

48. As a result of Kaiser' conduct, SJN has suffered damages in the sum of $474,942.01.

SECOND CAUSE OF ACTION

(BREACH OF IMPLIED CONTRACT)

49. Plaintiff realleges and incorporates as if fully stated herein each and every allegation contained above and incorporates the same herein by this reference as though set forth in full.

50. Plaintiff has performed each and every obligation, condition, and covenant required of it in accordance with oral representations made by Defendant and an implied contract based upon prior dealing. Plaintiff rendered medical services to patients insured by Defendant. Plaintiff thereafter submitted valid claims for reimbursement for such services to Defendant in conformity with Defendant's requirements and based upon prior identical transactions between the parties. Plaintiff and Defendant have maintained a long standing business relationship involving these transactions. Plaintiff has demanded that Defendant pay Plaintiff pursuant to its obligation to reimburse Plaintiff for valuable medical services rendered to patients insured by Defendant.

51. Defendant has breached its obligation to reimburse Plaintiff by unreasonably refusing to pay, and continuing to withhold, reimbursement funds due and payable to Plaintiff.

52. Defendant further breached its contract with Plaintiff by making unreasonable demands on Plaintiff, improperly denying Plaintiff's claims, and forcing Plaintiff to institute this litigation to obtain its reimbursement.

53. As a direct and proximate result of the actions of Defendant, Plaintiff has incurred substantial financial damage in addition to the $542,000 reimbursement monies owed to Plaintiff.

54. As a direct and proximate result of the actions of Defendant, Plaintiff has incurred and will continue to incur economic losses.

55. As a direct result of Defendant's breach of contract, Plaintiff has incurred attorney's fees and costs as a result of efforts to secure the reimbursement monies owed by Defendant to Plaintiff.

56. Plaintiff has been damaged in that it has not received the value of the contract it bargained for, it has not received reimbursements owed to it by Defendant for the value of the medical services, and it has not received any interest on the delayed reimbursements monies.

THIRD CAUSE OF ACTION

(BREACH OF THE IMPLIED COVENANT OF GOOD FAITH AND FAIR DEALING)

57. Plaintiff realleges and incorporates as if fully stated herein each and every allegation contained above and incorporates the same herein by this reference as though set forth in full.

58. Plaintiff provided valuable medical services to patients insured by Defendant with the understanding and expectation, which was clearly understood by Defendant based upon oral representations and prior conduct of the Defendant, that Defendant would act in good faith and deal fairly pursuant to the implied contract.

59. Defendant has tortuously breached its implied covenant of good faith and fair dealing arising from the implied contract by unreasonably withholding the reimbursement monies due to Plaintiff.

60. Defendant has tortuously breached its implied covenant of good faith and fair dealing arising from the implied contract by unreasonably underpaying Plaintiff by $474,942.01.

61. In the absence of a reasonable basis for doing so, and with full knowledge and/or reckless disregard of the consequences, Defendant wrongfully denied Plaintiff the reimbursement monies with the specific knowledge that its denial would result in catastrophic financial hardship to Plaintiff.

62. Defendant engaged and continues to engage in a course of conduct to further its own economic interests and in violation of its obligations to Plaintiff and Defendant's insured.

63. Defendant's conduct described herein constitutes part of Defendant's overall scheme to reduce the costs of legitimate reimbursement claims. Defendant's conduct as described herein constitutes an illegal pattern and practice so pervasive as to amount to a general unfair and unlawful business practice.

64. Defendant's conduct described herein was done with a conscious disregard of Plaintiff's rights and was done with the intent to vex, injure, or annoy Plaintiff such as to constitute oppression, fraud, or malice under Civil Code Section 3294, entitling Plaintiff to punitive damages in an amount appropriate to punish or set an example of Defendant.

65. Defendant's conduct described herein was undertaken by Defendant's officers or managing agents, identified herein as DOES 1 through 20, who were responsible for supervision, operation, reports, communications, and/or decisions. The afore-described conduct of said managing agents and individuals was therefore undertaken on behalf of Defendant. Defendant further had advanced

knowledge of the action and conduct of said individuals whose actions and conduct were ratified, authorized, and approved by managing agents whose precise identities are unknown to Plaintiff at this time and are therefore identified and designated herein as DOES 1 through 20, inclusive.

66. As a proximate result of the aforementioned wrongful conduct of Defendant, Plaintiff has suffered, and will continue to suffer in the future, damages under the contract, plus interest in an amount exceeding the $474,942.01 reimbursement monies owed to Plaintiff.

67. As a further direct and proximate result of the conduct of Defendant, Plaintiff has been obligated to expend and incur liability for costs of suit, attorneys' fees, and related expenses in an amount to be determined at the time of trial.

FOURTH CAUSE OF ACTION

(UNJUST ENRICHMENT)

68. Plaintiff realleges and incorporates as if fully stated herein each and every allegation contained above and incorporates the same herein by this reference as though set forth in full.

69. Plaintiff conferred a tangible economic benefit on Defendant by rendering medical services to patients insured by Defendant. Plaintiff expected that Defendant would reimburse Plaintiff for the value of the services appropriately to further the interests, objective, and legal obligations of both the Defendant and Plaintiff.

70. As a result of Defendant's deceptive, fraudulent, negligent, and misleading conduct, as further described in this Complaint, Defendant was enriched at the expense of the Plaintiff. Defendant did not reimburse Plaintiff for the full value of Plaintiff's services and instead was enriched in the amount of $474,942.01.

71. Under the circumstances, it would be against equity and good conscious to permit Defendant to retain the ill-gotten benefits that it received from Plaintiff.

72. It is unjust for Defendant to retain the monies because Plaintiff performed highly skilled and valuable services for patients insured by Defendant with the expectation of being reimbursed for the value of those services.

73. It would thus be unjust and inequitable for Defendant to retain the benefit without restitution or disgorgement of reimbursement monies owed to Plaintiff.

FIFTH CAUSE OF ACTION

(UNFAIR BUSINESS PRACTICES)

(Business and Professions Code Sections 17200, et seq.)

74. Plaintiff realleges and incorporates as if fully stated herein each and every allegation contained above and incorporates the same herein by this reference as though set forth in full.

75. Defendant failed to adequately compensate Plaintiff after Plaintiff provided valuable medical services to patients insured by Defendant and after Plaintiff submitted proper, valid claims for reimbursement, both with the expectation of reimbursement by Defendant based on oral representations and a pattern of prior dealing between Plaintiff and Defendant.

76. Defendant denied Plaintiff's reimbursement claims without fully and adequately investigating. Defendant's conduct described herein constitutes part of Defendant's overall scheme to reduce the costs of reimbursement claims brought by out-of-network providers such as Plaintiff. Defendant's conduct as described herein constitutes an illegal pattern and practice so pervasive as to form a general business practice which is forbidden by Business and Professions Code §§ 17200, et seq.

77. Plaintiff seeks injunctive relief prohibiting Defendant's continued violation of the above described unlawful conduct which constitutes an unfair business practice. Plaintiff seeks restitutionary relief in the form of Defendant's disgorgement of profits gained through its unlawful and unfair business practice. Members of the public have been, continue to be, and are likely to be deceived by Defendant's continued unlawful conduct as described herein.

78. Plaintiff and other similarly-situated out-of-network medical providers that render valuable medical services to patients insured by Defendant have no adequate remedy at law to protect themselves from Defendant's pervasive fraudulent and unfair business practice.

79. A remedy at law is inadequate because insureds must initiate litigation after Defendant's unlawful conduct has occurred. Once a remedy at law matures, Defendant's actions will have already violated California law by compelling medical providers, including Plaintiff, to initiate litigation to obtain reimbursement monies. As an example of this litigation delay, Plaintiff accrued a balance of $542,000 with the expectation of reimbursement by Defendant. This result and delay in assertion of rights through litigation is all to the benefit of Defendant.

80. Granting injunctive relief will protect other medical providers who render valuable medical services to patients insured by Defendant. Defendant, by its conduct as described herein, has engaged in unfair, unlawful, and fraudulent business practices intended to deceive other California medical service providers, including Plaintiff. Injunctive relief will bar Defendant from future exploitation of Plaintiff and other medical service provider and future violations of California law.

SIXTH CAUSE OF ACTION

(QUANTUM MERUIT)

81. SJN incorporates by reference and re-alleges paragraphs above as though set forth in full.

82. By impliedly providing SJN with authorization and approval for the medical care and treatment of their member patients described above and impliedly representing to SJN that SJN should continue to care and treat for those patients, until their condition stabilized, Kaiser both expressly and impliedly requested that SJN provide care and treatment to their members.

83. Pursuant to Kaiser's express and implied request, SJN did indeed provide medical care and treatment to the patients above to the best of SJN's ability until their date of discharge.

84. SJN's provision of medical care and treatment to the patients above was intended to and in fact benefited Kaiser in that the patients above were provided with medical care and treatment which Kaiser was obliged to provide pursuant to the terms of its Policy with those patients.

SEVENTH CAUSE OF ACTION

(RECOVERY OF PAYMENT FOR SERVICES RENDERED)

85. Plaintiff realleges and incorporates as if fully stated herein each and every allegation contained above and incorporates the same herein by this reference as though set forth in full.

86. At all relevant times, prior to rendering services, Plaintiff contacted Defendants, to obtain permission, authorization, and consent to render care to the Patient; to obtain verification of coverage; and to obtain Defendants' commitment, agreement and assent that it would provide payment, coverage and indemnification for the services to be rendered to the Patient by Plaintiff. For the Patient, Defendants authorized and consented to performance of medical services at the facilities operated and owned by Plaintiff and by physicians and medical providers affiliated with Plaintiff and committed to pay for, reimburse, indemnify, cover or otherwise provide insurance benefits and payments to Plaintiff

at the lesser of billed charges or usual, customary and reasonable charges.

87. Plaintiff has demanded that Defendants pay for the medical treatment provided to the patients, and has submitted statements to Defendants for the medical services rendered to the patients. Defendants have failed and refused to pay, and continue to refuse to pay the Plaintiff for such services rendered at appropriate rates and have underpaid Plaintiff by failing and refusing to pay usual, customary and reasonable rates. Accordingly, there is now due and owing an unpaid sum, plus statutory interest thereon.

PRAYER FOR RELIEF

WHEREFORE, SJN prays for judgment as follows:

For All Causes of Action:

1. for the principal sum of $474,942.01;

2. for interest on such principal sum at the rate of fifteen percent (15%) per annum, pursuant to Cal. Health & Safety Code § 1371;

3. for pre-judgment interest on such principal sum, at the legal rate, pursuant to Cal. Civ. Code § 3287(a);

4. for all costs of suit incurred herein;

5. for attorney's fees and costs; and,

6. for such other and further relief as the Court deems just and proper.

DEMAND FOR JURY TRIAL

Plaintiff SAN JOSE NEUROSPINE hereby demands a jury trial by jury.

DATED: September 15, 2016

VAN PARYS LAW

BY: _____
NICHOLAS H. VAN PARYS
Attorney for Plaintiff SAN JOSE NEUROSPINE