

Electronically FILED by Superior Court of California, County of Los Angeles on 08/16/2019 01:48 PM Sherri R. Carter, Executive Officer/Clerk of Court, by M. Barel, Deputy Clerk

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9 SUPERIOR COURT OF CALIFORNIA
10 COUNTY OF LOS ANGELES, CENTRAL DISTRICT
11 LIMITED JURISDICTION

12 RYAN SPIVAK INTEGRATIVE)
13 PLASTIC SURGERY, INC., a California)
14 Corporation)

15 Plaintiff,

16 v.

17 KAISER FOUNDATION HEALTH)
18 PLAN INC., a California corporation)
19 and DOES 1 through 20,)

20 Defendants.

21 CASE NO.:

22 COMPLAINT FOR:

- 23 1. RECOVERY OF PAYMENT FOR
24 SERVICES RENDERED;
25 2. RECOVERY OF PAYMENT ON OPEN
26 BOOK ACCOUNT;
27 3. *QUANTUM MERUIT*;
28 4. BREACH OF IMPLIED CONTRACT;
and

[JURY TRIAL REQUESTED]
Damages: UNLIMITED: Over \$25,000

1 Plaintiff Ryan Spivak Integrative Plastic Surgery, Inc. (hereafter referred to as "RSIPS")
2 complains and alleges:

3 **GENERAL ALLEGATIONS**

- 4 1. RSIPS is and at all relevant times was a corporation organized and existing under the
5 laws of the State of California, and was and is a resident of the County of Los Angeles.
- 6 2. RSIPS is and at all relevant times was in the business of providing Patient with medical
7 services, medications, devices, and any other services related to healthcare. RSIPS is
8 pursuing the accounts receivable and related claims by the Physician or health care
9 providers (hereinafter referred to as "Physician"), who were fully licensed, certified, and
10 in good standing under the laws of the State of California who performed the medical
11 services for which it has not been properly paid.
- 12 3. Physician provided medical care, services, treatment, and/or procedures and services to
13 members, subscribers and insureds of KAISER FOUNDATION HEALTH PLAN INC.,
14 a California Corporation, and DOES 1 through 20, inclusive (hereafter referred to as
15 "DEFENDANT" or "DEFENDANTS"). Physician became entitled to reimbursement,
16 payment and/or indemnification from DEFENDANTS for those services and supplies
17 rendered.
- 18 4. DEFENDANT is a California corporation licensed to do business in and was doing
19 business in the State of California, as a medical insurer or Health Plan. RSIPS is
20 informed and believes that DEFENDANT is licensed by the Department of Managed
21 Health to transact the business of medical insurance in the State of California.
22 DEFENDANT is, in fact, transacting the business of medical insurance in the State of
23 California and is thereby subject to the laws and regulations of the State of California.

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- 1 5. The true names and capacities, whether individual, corporate, associate, or otherwise, of
2 DEFENDANTS are unknown to RSIPS, who therefore sues said DEFENDANTS by
3 such fictitious names. RSIPS is informed and believes and thereon alleges that each of
4 the DEFENDANTS designated herein as a DOE is legally responsible in some manner
5 or to some extent for the events and happenings referred to herein and legally caused
6 injury and damages proximately thereby to RSIPS. RSIPS will seek leave of this Court
7 to amend this Complaint to insert their true names and capacities in place and instead of
8 the fictitious names when they become known to it.
9
- 10 6. At all times herein mentioned, unless otherwise indicated, DEFENDANTS were the
11 agents and/or employees of each of the remaining DEFENDANTS, and were at all times
12 acting within the purpose and scope of said agency and employment, and each
13 DEFENDANT has ratified and approved the acts of his agent. At all times herein
14 mentioned, DEFENDANTS had actual or ostensible authority to act on each other's
15 behalf in certifying or authorizing the provision of medical services; processing and
16 administering the claims and appeals; pricing the claims; approving or denying the
17 claims; directing each other as to whether to pay and/or how to pay claims; issuing
18 remittance advices and explanations of benefits statements; and, making payments to
19 RSIPS and its Patient.
20

FACTS

- 21 7. This complaint arises out of the failure of DEFENDANTS to make payments due and
22 owing to Physician for surgical care, treatment, and procedures provided to a single
23 patient (hereafter referred to as "Patient"), who was an insured, member, policyholder,
24 certificate-holder, or was otherwise covered for health, hospitalization, pharmaceutical
25 expenses, and major medical insurance through policies or certificates of insurance
26 issued and underwritten by DEFENDANTS.
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- 1 8. None of the claims and/or causes of action in this Complaint are derivative of the
2 contractual rights of the patient. In no way does RSIPS seek to enforce the contractual
3 rights of the Patient through the Patient' insurance contracts, policies, certificates of
4 coverage, and/or any other written insurance agreements between DEFENDANTS and
5 any Patient. The claims and causes of action are based upon the relationship and
6 interactions between RSIPS and DEFENDANTS and upon the fact that the Patient were
7 covered by DEFENDANTS.
8
- 9 9. RSIPS is informed and believes that the Patient was insured by DEFENDANT either as
10 a subscriber to coverage or a dependent of a subscriber to coverage under a plan or
11 policy or certificate of insurance issued and underwritten by DEFENDANT. RSIPS is
12 informed and believes that the Patient entered into a valid insurance agreement with
13 DEFENDANT for the specific purpose of ensuring that the Patient would have access to
14 medically necessary treatments, care, procedures and surgeries by medical practitioners
15 like the Physician and ensuring that DEFENDANT would pay for the health care
16 expenses incurred by the Patient.
17
- 18 10. RSIPS is informed and believes, and on such information and belief alleges, that
19 DEFENDANT received, and continues to receive, valuable premium payments from the
20 Patient and/or other consideration from the Patient under the subject policies applicable
21 to the Patient.
22
- 23 11. At all relevant times, the Physician provided medically necessary and appropriate
24 services, care, treatment, and/or procedures to the Patient holding valid insurance
25 policies or certificates issued by DEFENDANT.
26
- 27 12. The Physician has a reputation for providing high quality care, treatment, and
28 procedures. Their charges for services are on par with the charges of other Physician in
the same general area for the same procedures and/or services. The Physician's billed
charges are reasonable, usual, and customary.

- 1 13. The Physician who provided medical services to the Patient was an "out-of-network
2 provider" who had no preferred provider contracts or other contracts with
3 DEFENDANT at the time that the surgeries or procedures were performed.
- 4 14. It is standard practice in the healthcare industry that when a medical provider enters into
5 a written preferred provider contract with a health plan such as DEFENDANT, that
6 medical provider agrees to accept reimbursement that is discounted from the medical
7 provider's total billed charges in exchange for the benefits of being a preferred or
8 contracted provider. Those benefits include an increased volume of business, because the
9 health plan provides financial and other incentives to its members to receive their
10 medical care and treatments from the contracted provider, such as advertising that the
11 provider is "in network," and allowing the members to pay lower co-payments and
12 deductibles to obtain care and treatment from a contracted provider. When health plans
13 such as DEFENDANT receive claims from in-network providers, they adjust the total
14 charges submitted by the in-network provider and pays an agreed upon contract rate to
15 the in-network provider.
16
- 17 15. Conversely, when a medical provider, such as Physician, does not have a written
18 contract with a health plan such that it is an out-of-network provider, the medical
19 provider receives no referrals from the health plan, as the health plan discourages its
20 members and subscribers from obtaining their care from the non-contracted providers.
21 The non-contracted provider has no obligation to reduce its charges and is entitled to
22 receive payment based on its billed or total charges for the services rendered (less any
23 copayments, coinsurance amounts, or deductibles owed by the Patient). The health plan
24 is not entitled to a discount from the medical provider's total billed charges for the
25 services rendered, because it is not providing the medical provider with the benefits of
26 increased patient volume that results from being an in-plan or in-network provider. In
27 such cases, when a health plan such as DEFENDANT receives claims from the out-of-
28

1 network provider for the total charges billed by the out-of-network provider and then
2 adjusts those claims, paying only those billed charges which are in an amount equivalent
3 to the usual and customary amount charged by similar providers rendering similar
4 treatment in the same or similar geographical location (less copayments, coinsurance,
5 and deductible amounts).

6 16. The Physician was legally required to offer and render medical services, care, treatment,
7 and/or procedures to the Patient, who was a member, insured, or subscriber of
8 DEFENDANT, because the services were emergent or authorized. For the Patient claims
9 at issue here, the Physician did in fact provide such emergency medical services, care,
10 treatment, and/or procedures to the Patient, as required by law. As part of Discovery
11 relevant Explanation of Benefits will be provided showing the patient name and the
12 relevant CPT codes that will show that each of these procedures was emergent. Due to
13 HIPAA regulations such information cannot be provided without protective order.

14 17. Because the medical services, care, treatment, and/or procedures rendered by the
15 Physician to the Patient were emergent in nature, DEFENDANT was required by law to
16 compensate the Physician at usual, customary, and reasonable rates.

17 18. The claims at issue in this case are comprised of claims for medical services, care,
18 treatment, and/or procedures provided to a member, insured or subscriber of
19 DEFENDANT by the Physician, for which payments were made to the Physician based
20 upon a sum unilaterally determined by DEFENDANT to be usual, customary, and
21 reasonable, which sums were not usual, reasonable, or customary and were far less than
22 the Physician's billed charges.

23 19. Following performance of medical services, care, treatment, and/or procedures by the
24 Physician upon the Patient, invoices, bills and claims were submitted to DEFENDANT
25 for adjustment and payment.

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1 20. Medical records pertaining to the Patient's medical services, care, treatment, and/or
2 procedures were provided to DEFENDANT by the Physician. All information requested
3 by DEFENDANT relating to the medical services, care, treatment, and/or procedure
4 provided by the Physician to the Patient was supplied to DEFENDANT by the
5 Physician.

6 21. At all relevant times, the Physician submitted their claims to DEFENDANT
7 accompanied with lengthy operative reports, chart notes, and other medical records. No
8 matter whether large or small, all of the Physician' claims are submitted using CPT
9 codes, Healthcare Common Procedure Coding System ("HCPCS"), and modifiers, as
10 necessary.

11 22. At all relevant times, the Physician submitted their claims to DEFENDANT
12 accompanied with lengthy operative reports, chart notes, and other medical records. No
13 matter whether large or small, all of the Physician' claims are submitted using CPT
14 codes, Healthcare Common Procedure Coding System ("HCPCS"), and modifiers, as
15 necessary.

16 23. At all relevant times, the Physician expected to be reimbursed by DEFENDANT at the
17 lesser of its billed charges or the then-current usual, customary, and reasonable rate,
18 which is defined by California law as follows:

19
20 A "usual" charge is the amount that is most consistently charged by an
21 individual physician for a given service. A "customary" charge is the amount
22 that falls within a specified range of usual charges for a given service billed by
23 most Physician with similar training and experience within a given geographical
24 area. A "reasonable" charge is a charge that meets the Usual and Customary
25 criteria, or is otherwise reasonable in light of the complexity of treatment of the
26 particular case. Under a UCR Program, the payment is the lowest of the actual
27 billed charge, the physician's usual charge or the area customary charges for any
28 given covered service.

- 1 24. Rather than simply pay the Physician the lesser of their billed charges or usual,
2 customary, and reasonable rates, DEFENDANTS instead deliberately reimbursed the
3 Physician claims at below usual, customary, and reasonable levels, forcing Physician to
4 exhaust time and energy first identifying and then appealing improperly reimbursed
5 claims.
- 6 25. DEFENDANTS have failed and refused to pay the correct monies, benefits, insurance
7 proceeds, or make any proper payment to the Physician in connection with the medically
8 necessary services, care, treatment, and/or procedures rendered to the Patient by the
9 Physician, or have substantially underpaid benefits for such services at inappropriately
10 low rates, using illegal and/or flawed databases and systems to calculate reimbursement
11 for non-contracted providers and have failed and refused to pay the claims at usual,
12 customary, and reasonable rates.
- 13 26. At all relevant times, DEFENDANT has improperly paid the Physician for medically
14 necessary and appropriate services rendered to DEFENDANT's insured at rates far
15 below the billed rates, even though there was no contractual relationship or preferred
16 provider relationship between the Physician and DEFENDANTS. For each of the Patient
17 claims at issue in this action, the Physician provided medical services to a member or
18 insured of DEFENDANT.
- 19 27. The rates paid by DEFENDANT were not reasonable, customary or usual, and were
20 arbitrary, capricious and inexplicable. Further, DEFENDANT has never explained how
21 they calculated, justified, rationalized or comprised their pricing and rate schedule for
22 non-contracted, out-of-network providers, such as the Physician.
- 23 28. The California Department of Managed Health Care has adopted regulations that define
24 the amount that health care service plans such as DEFENDANTS are obligated to pay
25 non-contracted providers such as the Physician. These regulations provide a
26 methodology for determining the rate to be paid to out-of-network emergency room
27
28

1 providers:

2 For contracted providers without a written contract and non-contracted
3 providers . . . the payment of the **reasonable and customary value** for the
4 health care services rendered based upon statistically credible information that
5 is updated at least annually and takes into consideration: (i) the provider's
6 training, qualifications and length of time in practice; (ii) the nature of the
7 services provided; (iii) the fees usually charged by the provider; (iv) prevailing
8 provider rates charged in the general geographic area in which the services were
9 rendered; (v) other aspects of the economics of the medical provider's practice
10 that are relevant; and (vi) and unusual circumstances in the case.

11 28 Cal. Code Regs. Section 1300.71(a)(3)(B) (Emphasis added). These definitions
12 are the same criteria used by California Courts to determine the *quantum meruit*
13 amounts that should be paid for services rendered by non-contracted providers by
14 insurers in California.

15 29. Based upon these criteria, the Physician's charges are reasonable and customary. The
16 Physician charged DEFENDANT the same fees that they charge all other payers.

17 30. RSIPS is informed and believes that DEFENDANT relied upon and utilized a flawed
18 database to make pricing determinations for the claims submitted by the Physician on
19 behalf of the Patient. DEFENDANT utilized that flawed database as a primary source of
20 data upon which it based its pricing determinations, even though DEFENDANT knew
21 that the data cannot and should not be used for that purpose. DEFENDANT was fully
22 aware that its database was not properly designed to determine usual, customary and
23 reasonable reimbursement amounts.

24 31. RSIPS is informed and believes and thereon alleges that DEFENDANT's system for
25 paying out-of-network claims is flawed, that DEFENDANT improperly manipulates the
26 data in its systems to underpay out-of-network medical provider claims, and that
27 DEFENDANT'S systems and methods for calculating such rates violate California law.
28 DEFENDANT has used flawed databases and systems to unilaterally determine what

1 amounts it pays to medical providers and has colluded with other insurers to artificially
2 underpay, decrease, limit, and minimize the reimbursement rates paid for services
3 rendered by non-contracted providers. The issue of flawed database has been
4 investigated by the U.S. Congress and New York Attorney General and has been the
5 source of numerous lawsuits and class action suits filed in connection with the databases
6 utilized (known as Ingenix).

7
8 32. RSIPS is informed and believes that there are a number of inherent flaws in
9 DEFENDANT's database, which make that database invalid and inappropriate for
10 setting usual, customary and reasonable rates. Among other flaws, DEFENDANT's
11 database:

- 12 a. Does not determine the numbers or types of providers in any geographic
13 area;
- 14 b. Does not determine the actual types of procedures performed within a
15 geographic area;
- 16 c. Collects charge data which is not representative of the actual number of
17 procedures performed within a geographic area;
- 18 d. Does not collect sufficient data to enable its users to determine whether the
19 data reflects the charges of providers with any particular degree of expertise
20 or specialization;
- 21 e. Does not collect sufficient provider-specific data to enable its users to
22 determine whether the charges are from one provider, from several
23 providers, or from only a minority subset of the providers in a geographic
24 area;
- 25 f. Fails to compare providers of the same or similar training and experience
26 level and, instead, combines and averages all provider charges by procedure
27 code without separating the charges of Physician and non-Physician;
28

- 1 g. Does not collect patient specific information such as age or medical history
2 or condition;
- 3 h. Does not ascertain the most common charge for the same service or
4 comparable service or supply;
- 5 i. Does not determine the place of service or type of facility;
- 6 j. Does not collect sufficient data to enable it or its users to determine an
7 appropriate medical market for comparing like charges;
- 8 k. Combines zip codes inappropriately, and uses zip codes instead of
9 appropriate medical markets;
- 10 l. Fails to compare procedures that use the same or similar resources (and
11 other costs) to the provider but, rather, indiscriminately combines all
12 provider charges by procedure code without regard to such factors;
- 13 m. Fails to compare procedures of the same or similar complexity by, among
14 other things, failing to record or account for CPT code modifiers;
- 15 n. Does not use appropriate statistical methodology;
- 16 o. Does not properly consider charging protocols and billing practices
17 generally accepted by the medical community or specialty groups;
- 18 p. Does not properly consider medical costs in setting geographic areas;
- 19 q. Lacks quality control, such as basic auditing, to ensure the validity;
20 completeness, representativeness, and authenticity of the data submitted;
- 21 r. Is subject to pre-editing by data contributors;
- 22 s. Reports charges that are systematically skewed downward;
- 23 t. Uses relative values and conversion factors to derive inappropriate usual,
24 customary and reasonable amounts;
- 25 u. Uses a methodology that does not comply with DEFENDANT'S
26 contractual definition of usual, customary and reasonable; and;
27
28

1 v. Purports to be confidential and/or proprietary, which prevents access to,
2 and scrutiny of, the data by members of their employers.

3 33. These and other flaws render DEFENDANT'S use of its data system invalid and
4 unlawful for determining usual, customary and reasonable rates. By systematically and
5 typically making usual, customary, and reasonable rate determinations without compliant
6 and valid data to substantiate its determinations, DEFENDANTS have breached their
7 obligations to reimburse Physician for out-of-network services. Accordingly, all past
8 usual, customary, and reasonable rate determinations based on DEFENDANT'S data
9 system should be overturned and disregarded.

10 34. DEFENDANT used other improper pricing methods to reduce reimbursement to out-of-
11 network providers. Accordingly, DEFENDANT violated, and continues to violate, its
12 legal obligations to Physician to pay usual, customary and reasonable rates of
13 reimbursement for services rendered to the Patient, insureds, subscribers, and members.

14 35. DEFENDANT has received previous claims from the Physician in relation to the same
15 patient which were paid at a full rate. As such, DEFENDANT knew the rates that the
16 Physician charged for various services. Moreover, DEFENDANT knew or should have
17 known the amounts charged by other medical providers for medical services, care, and
18 treatment, since it had received, reviewed and processed, numerous claims prior to
19 processing the claims at issue in this litigation. It is standard practice in the healthcare
20 industry for medical providers (whether in-network or not) to submit claims and bills
21 showing the total charges to health plans such as DEFENDANT and for DEFENDANT
22 to price those claims, based either upon the total charges or the contractual rates offered
23 to network providers.

24 36. The Physician has also been disparaged by the pervasive under-reimbursement scheme.
25 When a patient refers to his/her evidence of coverage documents promulgated by
26 DEFENDANTS, he/she is led to believe that when he/she seeks out-of-network care
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1 their charges will be paid by DEFENDANTS at the "usual and customary rate" of
2 similar Physician for a similar service in a similar area. When a patient obtains out-of-
3 network treatment from providers such as the Physician and the provider submits the bill
4 to the insurer, a patient learns for the first time that he/she will not be fully reimbursed
5 because the doctor's charges are alleged by DEFENDANT to exceed the usual and
6 customary rate. The physician-patient relationship is undermined, as the Physician has
7 been branded a charlatan whose bills are inflated and unreasonable.

8
9 37. At all relevant times, DEFENDANT harmed the Physician by making improper usual,
10 customary, and reasonable rate and pricing determinations that reduced the lawful
11 reimbursement amounts for out-of-network providers without valid or compliant data to
12 support such determinations. DEFENDANT further harmed the Physician by
13 misapplying in-network policies to out-of-network provider claims, and by delaying
14 payments to out-of-network providers under the pretext of negotiation. As a result of
15 these actions, the Physician were financially harmed and forced to exhaust significant
16 time and resources appealing DEFENDANT's unlawful determination through a process
17 deliberately designed to deny, delay, and impede out-of-network physician providers
18 from obtaining their rightful reimbursement.

19
20 38. Upon information and belief, DEFENDANT used and continues to use flawed database
21 data, among other sources, to understate the true market rates of medical care performed
22 by out-of-network providers. The improper use of this data has caused both Patient and
23 out-of-network providers to experience significant losses. Patient are harmed because
24 payers like DEFENDANT are not reimbursing out-of-network services at appropriate
25 levels, which results in out-of-network providers increasingly billing their Patient for
26 amounts charged, which exceed the amounts DEFENDANT covers. Out-of-network
27 providers like Physician are harmed because they are not always able to collect these
28 balances from Patient and are forced to take a loss for their services. Moreover, because

1 out-of-network providers are often unaware of the scheme that results in payers like
2 DEFENDANT failing to pay appropriate usual, customary and reasonable rates, they are
3 either powerless to appeal any such improper determinations or their efforts to appeal
4 these determinations are futile. DEFENDANT, by contrast, benefits from paying out-of-
5 network providers at below market rates. If, for example, out-of-network providers fail
6 to realize that the scheme is the cause of their underpayment, DEFENDANT has
7 unlawfully retained money which otherwise belongs to the Physician for the services
8 provided. DEFENDANT's ambiguity regarding its method for calculating usual,
9 customary and reasonable rates reflects its participation in this deceptive practice.

10
11 39. DEFENDANT's explanation of benefit statements are initially uninformative, false, and
12 misleading regarding the use of usual, customary, and reasonable rates. This ambiguity
13 has resulted in the inconsistent application of usual, customary and reasonable rates to
14 deny Physician their lawful reimbursement. Usual, customary, and reasonable rates
15 should be applied consistently by DEFENDANTS, but instead are selectively used to
16 deny or diminish lawful reimbursement to Physician and other out-of-network providers.

17 40. The Physician's explanation of benefits and remittance advices received from
18 DEFENDANTS often state that their billed charges purportedly exceed the usual,
19 customary, and reasonable rate for the geographic area where the services were
20 performed. However, nowhere on the explanation of benefit statements, remittance
21 advices, or elsewhere in any other correspondence sent to the Physician do
22 DEFENDANTS discuss or identify how they actually calculate usual, customary, and
23 reasonable rates. The Explanation of Benefit statements do not even specify whether
24 database data or some other methodology was used in these calculations. Instead, the
25 explanation of benefit statements plainly state that the rates have been determine by
26 DEFENDANTS. With its methods for calculating usual, customary, and reasonable rates
27 shrouded in a veil of secrecy, DEFENDANTS have been able to derive improper rates
28 using faulty data and apply them to out-of-network providers such as the Physician.

1 **FIRST CAUSE OF ACTION**

2 **FOR RECOVERY OF PAYMENT FOR SERVICES RENDERED**

3 **(AS AGAINST ALL DEFENDANTS)**

4 41. Plaintiff incorporates all allegations set forth in the above paragraphs as though fully set
5 forth herein.

6 42. At all times herein mentioned, Physician provided medical services, care, treatment,
7 and/or procedures to Patient as required by law (because the medical services provided
8 were emergency services), thereby benefiting DEFENDANTS and the Patient.

9 43. At all times herein mentioned, DEFENDANTS were required by law to pay usual,
10 reasonable, and customary rates for the emergency care or authorized or deemed
11 authorized post stabilization care provided by the Physician to the Patient, who were
12 members or subscribers of DEFENDANT, California Health and Safety Code § 1371.4;
13 *Bell v. Blue Cross*, 131 Cal.App.4th 211. The code and Knox-Keene Act apply to all
14 Health Care Service Plans and the DEFENDANT administered a Health Care Service
15 Plan and is therefore subject to these rules.

16 44. At all relevant times, the Physician rendered care, treatment, and services to the
17 Patient in good faith and in reliance upon the legal requirement that insurers pay for the
18 emergency medical care or authorized or deemed authorized post stabilization care of
19 those they insure. DEFENDANTS had a duty to pay, reimburse, indemnify, and cover
20 the Physician for the care, treatment and services rendered by the Physician to the Patient
21 pursuant to California Health & Safety Code §§ 1371, 1371.35, and 1371.4 following the
22 rendition of services and treatment by the Physician to the Patient. Further,
23 DEFENDANTS had a duty to pay usual, customary, and reasonable rates for the services
24 rendered by the Physician in compliance with 28 California Code of Regulations
25 §1300.71 et seq. For the Patient, DEFENDANTS have failed and refused to comply with
26 28 California Code of Regulations § 1300.71 et seq. At all relevant times, the Physician
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28

1 rendered care and treatment to the Patient. DEFENDANT had a duty to pay, reimburse
2 and cover the cost of such treatment and services by payment to the Physician for the
3 medical services, care, treatment, and/or procedures rendered by the Physician to the
4 Patient, pursuant to California Health & Safety Code §§ 1371, 1371.35, and 1371.4, and
5 was prohibited from denying or refusing coverage, payment, indemnity, or
6 reimbursement for the cost for treatment and services rendered by the Physician to the
7 Patient. Further, DEFENDANTS have a duty to pay usual, customary, and reasonable
8 rates for the services rendered by RSIPs in compliance with 28 California Code of
9 Regulations § 1300.71 et seq. and have failed and refused to pay usual, customary, and
10 reasonable amounts.
11

12 45. At all relevant times, 28 California Administrative Code § 1300.71 et seq. required that
13 DEFENDANTS reimburse the Physician for the claims submitted on behalf of the
14 Patient within 45 days after DEFENDANTS received the Patient's claims from the
15 Physician. 28 Cal. Admin. Code Tit. 28 Section 1300.71(a)(3) defines the manner and
16 method by which reasonable and customary rates are to be defined by DEFENDANTS,
17 providing:
18

19 (B) For contracted providers without a written contract and non-
20 contracted providers, except those providing services described in
21 paragraph (C) below: the payment of the reasonable and customary
22 value for the health care services rendered based upon statistically
23 credible information that is updated at least annually and takes into
24 consideration: (i) the provider's training, qualifications, and length of
25 time in practice; (ii) the nature of the services provided; (iii) the fees
26 usually charged by the provider; (iv) prevailing provider rates charged
27 in the general geographic area in which the services were rendered; (v)
28 any unusual circumstances in the case; and (C) For non-emergency
services provided by non-contracted providers to PPO and POS
enrollees: the amount set forth in the enrollee's Evidence of Coverage.

1 46. As a proximate result of the violation of California Health & Safety Code §§ 1371.8 and
2 1371, California Insurance Code § 796.04, California Insurance Code § 796.04 and/or 28
3 C.C.R. § 13700.1 by DEFENDANT, which acts were intentional, willful and knowing,
4 the Physician has been underpaid for the medical services, care, treatment, and/or
5 procedures provided to the Patient. By their acts and omissions, DEFENDANTS have
6 failed and refused to pay the usual, customary, and reasonable value for the services
7 rendered by the Physician to the Patient.
8

9 47. The Physician is owed reimbursement, compensation, and payment of the cost of the
10 medical services, care, treatment, and/or procedures which they rendered and provided to
11 the Patient at the Physician's billed rates or at rates equivalent to the usual, customary,
12 and reasonable value for their services, in conformance with the legal requirements that
13 they provide emergency care or authorized or deemed authorized post stabilization care
14 to any patient and that the insurance of any patient who received emergency care or
15 authorized or deemed authorized post stabilization care pay the provider of the care at
16 usual, customary, and reasonable rates.
17

18 48. The Physician has demanded that DEFENDANT pay for the medical treatment provided
19 to the Patient and has submitted statements to DEFENDANT for the medical services
20 rendered to the Patient.

21 49. DEFENDANTS have failed and refused to pay and continue to refuse to pay the
22 Physician for such services rendered at appropriate rates and have underpaid the
23 Physician by failing and refusing to pay usual, customary and reasonable rates.
24 Accordingly, there is now due and owing an unpaid sum, plus statutory interest thereon.
25

26 50. The Patient Protection and Affordable Care Act (PPACA) §1302 mandates that certain
27 "Essential Health Benefits" must be covered by all health plans, and emergency services
28 is one of them. *PPACA § 1302(b)(1)(B)*. The law states that "a qualified health plan will

1 not be treated as providing coverage for the essential health benefits... unless the plan
2 provides that... (ii) if such services are provided out-of-network, the cost-sharing
3 requirement (expressed as a copayment amount or coinsurance rate) is the same
4 requirement that would apply if such services were provided in-network." *PPACA §*
5 *3102(b)(4)(E)*. Prudent practices will note that the cost-sharing requirement imposed
6 upon an enrollee for emergency services provided in-network is 0%. Thus, federal law
7 requires the health plan to reimburse an out-of-network provider at 100% of billed
8 charges for emergency services in order to ensure the same cost sharing requirement of
9 0% for out-of-network services.
10

11 51. It is therefore clear that the Defendants own Contract/Plan with the Patient requires that
12 the Defendant must pay Physician for Emergency Care at a rate equivalent to the
13 Copayment or Coinsurance rate with the in- Network rates within that Contract/Plan.
14 The Patient has had such Emergency care and the Physician who has provided that care
15 has been denied payment in breach of that same said contract. For the avoidance of
16 doubt the Plaintiff is not looking to stand in the shoes of the Patient/Insured, however
17 does point to the contract as evidence of the Defendant's failure to pay UCR rates.
18

19 52. In any event, the Defendant must be bound by the terms of the Contract/Plan that they
20 have between them and the patient which covers scenarios where the Patient requires
21 emergency care. It is understood and expected that the wording will include reference to
22 Usual, Customary and Reasonable Rates in respect of the payment for those emergency
23 services. In the event that usual, customary and reasonable rates is not specifically
24 defined in the Contract/Plan then the Definition should be applied as described in the
25 Health and Safety Code.
26
27
28

1 **SECOND CAUSE OF ACTION:**
2 **FOR RECOVERY OF PAYMENT ON OPEN BOOK ACCOUNT**
3 **(AS AGAINST ALL DEFENDANTS)**

4 53. Plaintiff incorporates all allegations set forth in the above paragraphs as though fully set
5 forth herein.

6 54. DEFENDANT has become indebted to the Physician on open book accounts for the
7 Patient, for money due in the sum to be determined at the time of trial for medical
8 services rendered by the Physician to the Patient.

9 55. The Physician have provided medical treatment to the Patient, and have maintained
10 contemporaneous, itemized and detailed records and statements of each medical service
11 provided to the Patient. The Physician has provided DEFENDANT with statements
12 itemizing the medical treatment provided to the Patient, along with an accounting of the
13 amounts owed by DEFENDANT.

14 56. DEFENDANT has refused to pay, and continue to refuse to pay, the Physician the billed
15 charges submitted by the Physician and/or the usual and customary charges owed
16 to the Physician for the treatment, surgeries, procedures and medical services provided to
17 the Patient. Accordingly, there is now due and owing an unpaid sum in an amount to be
18 determined at the time of trial, plus statutory interest.
19
20
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22

23 **THIRD CAUSE OF ACTION:**
24 **FOR QUANTUM MERUIT**
25 **(AGAINST ALL DEFENDANTS)**

26 57. Plaintiff incorporates all allegations set forth in the above paragraphs as though fully set
27 forth herein.
28

- 1 58. As required by law (because the medical services provided were emergency services),
2 the Physician provided surgeries, procedures, medical treatments, and other medical
3 services to the Patient, at the express and/or implied request of the DEFENDANT,
4 thereby benefitting DEFENDANT and the Patient.
5
- 6 59. DEFENDANTS have failed and refused to pay the Physician the appropriate amounts
7 incurred by the Physician in rendering medical services, care, treatment, and/or
8 procedures to the Patient, have underpaid those costs and have failed and refused to pay
9 the usual, reasonable, and customary costs of those services.
10
- 11 60. At all times herein mentioned, DEFENDANTS were required by law to pay usual,
12 reasonable, and customary rates for the emergency care provided by the Physician to the
13 Patient, who were members or subscribers of DEFENDANT. California Health and
14 Safety Code § 1371.4; *Bell v. Blue Cross*, 131 Cal.App.4th 211.
15
- 16 61. DEFENDANT is required to reimburse the Physician at a *quantum meruit* rate for all
17 services rendered to the enrollees, the Patient. The *quantum meruit* amount owed by
18 DEFENDANT to the Physician is determined according to the customary charges that
19 would be billed by the Physician and/or other Physician in the absence of preferred
20 provider or participating provider contractual rates. Based upon DEFENDANT's request
21 that the Physician render treatment, surgeries, procedures and medical services to the
22 Patient, and the fact that DEFENDANT was benefitted by the provision of such services
23 by the Physician, an obligation on the part of DEFENDANT to make restitution to the
24 Physician arose.
25
- 26 62. In *Regents of the University of California v. Principal Financial Group*, 412 F.Supp.2d.
27 1037, 1042 (N.D. Cal. 2006), the federal trial court held that California law no longer
28 requires that a defendant be benefitted in order for a *quantum meruit* claim to lie. It
found that: In *Earhart v. William Low Company*, 25 Cal.3d. 503, 511, 158 Cal.Rptr. 887,

1 600 P.2d. 1344 (1979), the California Supreme Court abrogated the common law
2 requirement that there be benefit to the defendant in a *quantum meruit* claim, noting
3 “that performance of services at another’s behest may itself constitute ‘benefit’ such that
4 an obligation to make restitution may arise.” Thus, the fact that Mr. Donner was the
5 direct beneficiary of the medical treatment does not bar plaintiff’s claim.” Thus the fact
6 that DEFENDANT's neither directly requested the treatment nor were the direct
7 beneficiary of the treatment is not a block to *quantum meruit*.

9 63. The *quantum meruit* rate for the medical treatment the Physician provided to the Patient
10 is an amount to be determined at trial. This amount represents the usual, customary and
11 reasonable cost or charge for the services rendered by the Physician. The Physician have
12 submitted statements to DEFENDANT for these amounts, and have made repeated
13 demands that they be paid for the medical treatment provided to the Patient at usual,
14 customary, and reasonable rates.

16 64. DEFENDANT has refused to pay, and continues to refuse to pay, the Physician for the
17 whole or any part of the sums owed to the Physician for the treatment, surgeries,
18 procedures and medical services provided to the Patient, at usual, customary and
19 reasonable rates. Accordingly, there is now due and owing an unpaid sum, plus statutory
20 interest.

21
22 **FOURTH CAUSE OF ACTION:**
23 **FOR BREACH OF IMPLIED CONTRACT**
24 **(AS AGAINST ALL DEFENDANTS)**
25

26
27 65. Plaintiff incorporates all allegations set forth in the above paragraphs as though fully set
28 forth herein.

1 66. RSIPS is informed and believes and thereon alleges that, at all relevant times herein, the
2 Patient had valid policies with DEFENDANT or was a member, subscriber, insured, or
3 was otherwise entitled to coverage, indemnification and payment as policyholders or
4 certificate-holders of insurance policies and certificates issued and underwritten by
5 DEFENDANT.
6

7 67. RSIPS is informed and believes that the Patient obtained such policies from
8 DEFENDANT for the specific purposes of (1) ensuring that the Patient would have
9 access to medically necessary treatments at healthcare facilities, and (2) ensuring that
10 DEFENDANT would pay for the healthcare expenses incurred by the Patient.

11 68. DEFENDANTS knew or reasonably should have known that its insureds would seek
12 medical treatment from the Physician.

13 69. RSIPS is informed and believes that DEFENDANT received and continues to receive
14 valuable premium payments from the Patient under the relevant insurance policies.
15

16 70. Since Physician were required by law to treat the Patient in emergency situations, they
17 agreed by implication to treat the Patient. DEFENDANTS, by law, were required to pay
18 Physician at the usual, customary, and reasonable rate for emergency services and
19 therefore agreed by implication to pay usual, customary, and reasonable rates to
20 Physician. California Health and Safety Code § 1371.4; *Bell v. Blue Cross*, 131
21 Cal.App.4th 211.
22

23 71. In consideration for the Physician' implied agreement to treat the Patient, DEFENDANT
24 implicitly agreed to reimburse the Physician for the expenses incurred by the Patient in
25 the course of being treated and undergoing surgeries or procedures rendered by the
26 Physician and agreed to pay the Physician a usual and customary rate for those services.

27 72. The Physician provided medical treatment to the Patient. DEFENDANT has refused to
28 pay, and continues to refuse to pay, the Physician for the part of the sums owed to the

1 Physician at appropriate rates for the treatment services provided to the Patient.
2 73. As a result of the foregoing breach, the Physician has been damaged by DEFENDANT
3 in an amount to be determined at trial. Accordingly, there is now due and
4 owing an unpaid sum, plus statutory interest thereon.
5

6 **PRAYER FOR RELIEF**

7 **WHEREFORE**, Plaintiff RYAN SPIVAK INTEGRATIVE PLASTIC SURGERY, INC.
8 prays for judgment against DEFENDANT as follows:
9

- 10 1. For compensatory damages in an amount to be determined, plus statutory interest;
11 2. For restitution in an amount to be determined, plus statutory interest;
12 3. For a declaration that Kaiser Foundation Health Plan Inc is obligated to pay plaintiff all
13 monies owed for medical services rendered to the Patient; and
14 4. For such other further relief the Court deems just and appropriate.
15

16 DATED: August 16, 2019

Respectfully submitted,

17
18
19 By: A. Nesbit

20 ALAN NESBIT, Esq.
21 Attorney for Plaintiff
22 RYAN SPIVAK INTEGRATIVE
23 PLASTIC SURGERY, INC.
24
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28

DEMAND FOR JURY TRIAL

Plaintiff, RYAN SPIVAK INTEGRATIVE PLASTIC SURGERY, INC. hereby demands a jury trial as provided by law.

DATED: August 16, 2019

Respectfully submitted,

By: A. Nesbit

ALAN NESBIT, Esq.
Attorney for Plaintiff
RYAN SPIVAK INTEGRATIVE
PLASTIC SURGERY, INC.

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