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

RYAN SPIVAK INTEGRATIVE PLASTIC SURGERY, INC., a California Corporation Plaintiff, v. KAISER FOUNDATION HEALTH PLAN INC., a California corporation and DOES 1 through 20, Defendants.	CASE NO.: COMPLAINT FOR: 1. RECOVERY OF PAYMENT FOR SERVICES RENDERED; 2. RECOVERY OF PAYMENT ON OPEN BOOK ACCOUNT; 3. *QUANTUM MERUIT*; 4. BREACH OF IMPLIED CONTRACT; and [JURY TRIAL REQUESTED] Damages: UNLIMITED: Over $25,000

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

GENERAL ALLEGATIONS

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

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

FACTS

7. This complaint arises out of the failure of DEFENDANTS to make payments due and owing to Physician for surgical care, treatment, and procedures provided to a single patient (hereafter referred to as "Patient"), who was an insured, member, policyholder, certificate-holder, or was otherwise covered for health, hospitalization, pharmaceutical expenses, and major medical insurance through policies or certificates of insurance issued and underwritten by DEFENDANTS.

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8. None of the claims and/or causes of action in this Complaint are derivative of the contractual rights of the patient. In no way does RSIPS seek to enforce the contractual rights of the Patient through the Patient' insurance contracts, policies, certificates of coverage, and/or any other written insurance agreements between DEFENDANTS and any Patient. The claims and causes of action are based upon the relationship and interactions between RSIPS and DEFENDANTS and upon the fact that the Patient were covered by DEFENDANTS.
9. RSIPS is informed and believes that the Patient was insured by DEFENDANT either as a subscriber to coverage or a dependent of a subscriber to coverage under a plan or policy or certificate of insurance issued and underwritten by DEFENDANT. RSIPS is informed and believes that the Patient entered into a valid insurance agreement with DEFENDANT for the specific purpose of ensuring that the Patient would have access to medically necessary treatments, care, procedures and surgeries by medical practitioners like the Physician and ensuring that DEFENDANT would pay for the health care expenses incurred by the Patient.
10. RSIPS is informed and believes, and on such information and belief alleges, that DEFENDANT received, and continues to receive, valuable premium payments from the Patient and/or other consideration from the Patient under the subject policies applicable to the Patient.
11. At all relevant times, the Physician provided medically necessary and appropriate services, care, treatment, and/or procedures to the Patient holding valid insurance policies or certificates issued by DEFENDANT.
12. The Physician has a reputation for providing high quality care, treatment, and 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.

13. The Physician who provided medical services to the Patient was an "out-of-network provider" who had no preferred provider contracts or other contracts with DEFENDANT at the time that the surgeries or procedures were performed.

14. It is standard practice in the healthcare industry that when a medical provider enters into a written preferred provider contract with a health plan such as DEFENDANT, that medical provider agrees to accept reimbursement that is discounted from the medical provider's total billed charges in exchange for the benefits of being a preferred or contracted provider. Those benefits include an increased volume of business, because the health plan provides financial and other incentives to its members to receive their medical care and treatments from the contracted provider, such as advertising that the provider is "in network," and allowing the members to pay lower co-payments and deductibles to obtain care and treatment from a contracted provider. When health plans such as DEFENDANT receive claims from in-network providers, they adjust the total charges submitted by the in-network provider and pays an agreed upon contract rate to the in-network provider.

15. Conversely, when a medical provider, such as Physician, does not have a written contract with a health plan such that it is an out-of-network provider, the medical provider receives no referrals from the health plan, as the health plan discourages its members and subscribers from obtaining their care from the non-contracted providers. The non-contracted provider has no obligation to reduce its charges and is entitled to receive payment based on its billed or total charges for the services rendered (less any copayments, coinsurance amounts, or deductibles owed by the Patient). The health plan is not entitled to a discount from the medical provider's total billed charges for the services rendered, because it is not providing the medical provider with the benefits of increased patient volume that results from being an in-plan or in-network provider. In such cases, when a health plan such as DEFENDANT receives claims from the out-of-

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

16. The Physician was legally required to offer and render medical services, care, treatment, and/or procedures to the Patient, who was a member, insured, or subscriber of DEFENDANT, because the services were emergent or authorized. For the Patient claims at issue here, the Physician did in fact provide such emergency medical services, care, treatment, and/or procedures to the Patient, as required by law. As part of Discovery relevant Explanation of Benefits will be provided showing the patient name and the relevant CPT codes that will show that each of these procedures was emergent. Due to HIPAA regulations such information cannot be provided without protective order.
17. Because the medical services, care, treatment, and/or procedures rendered by the Physician to the Patient were emergent in nature, DEFENDANT was required by law to compensate the Physician at usual, customary, and reasonable rates.
18. The claims at issue in this case are comprised of claims for medical services, care, treatment, and/or procedures provided to a member, insured or subscriber of DEFENDANT by the Physician, for which payments were made to the Physician based upon a sum unilaterally determined by DEFENDANT to be usual, customary, and reasonable, which sums were not usual, reasonable, or customary and were far less than the Physician's billed charges.
19. Following performance of medical services, care, treatment, and/or procedures by the Physician upon the Patient, invoices, bills and claims were submitted to DEFENDANT for adjustment and payment.

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

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

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

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

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

24. Rather than simply pay the Physician the lesser of their billed charges or usual, customary, and reasonable rates, DEFENDANTS instead deliberately reimbursed the Physician claims at below usual, customary, and reasonable levels, forcing Physician to exhaust time and energy first identifying and then appealing improperly reimbursed claims.

25. DEFENDANTS have failed and refused to pay the correct monies, benefits, insurance proceeds, or make any proper payment to the Physician in connection with the medically necessary services, care, treatment, and/or procedures rendered to the Patient by the Physician, or have substantially underpaid benefits for such services at inappropriately low rates, using illegal and/or flawed databases and systems to calculate reimbursement for non-contracted providers and have failed and refused to pay the claims at usual, customary, and reasonable rates.

26. At all relevant times, DEFENDANT has improperly paid the Physician for medically necessary and appropriate services rendered to DEFENDANT's insured at rates far below the billed rates, even though there was no contractual relationship or preferred provider relationship between the Physician and DEFENDANTS. For each of the Patient claims at issue in this action, the Physician provided medical services to a member or insured of DEFENDANT.

27. The rates paid by DEFENDANT were not reasonable, customary or usual, and were arbitrary, capricious and inexplicable. Further, DEFENDANT has never explained how they calculated, justified, rationalized or comprised their pricing and rate schedule for non-contracted, out-of-network providers, such as the Physician.

28. The California Department of Managed Health Care has adopted regulations that define the amount that health care service plans such as DEFENDANTS are obligated to pay non-contracted providers such as the Physician. These regulations provide a methodology for determining the rate to be paid to out-of-network emergency room

providers:

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

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

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

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

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

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

32. RSIPS 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, 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 Physician and non-Physician;

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 DEFENDANT'S 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 by members of their employers.

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

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

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

36. The Physician has also been disparaged by the pervasive under-reimbursement scheme. When a patient refers to his/her evidence of coverage documents promulgated by DEFENDANTS, he/she is led to believe that when he/she seeks out-of-network care

their charges will be paid by DEFENDANTS at the "usual and customary rate" of similar Physician for a similar service in a similar area. When a patient obtains out-of-network treatment from providers such as the Physician and the provider submits the bill to the insurer, a patient learns for the first time that he/she will not be fully reimbursed because the doctor's charges are alleged by DEFENDANT to exceed the usual and customary rate. The physician-patient relationship is undermined, as the Physician has been branded a charlatan whose bills are inflated and unreasonable.

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

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

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

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

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

FIRST CAUSE OF ACTION

FOR RECOVERY OF PAYMENT FOR SERVICES RENDERED

(AS AGAINST ALL DEFENDANTS)

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

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

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

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

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

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

> (B) For contracted providers without a written contract and non-contracted providers, except those providing services described in paragraph (C) below: the payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration: (i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) 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.

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

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

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

49. DEFENDANTS have failed and refused to pay and continue to refuse to pay the Physician for such services rendered at appropriate rates and have underpaid the Physician 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.

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

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

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

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

SECOND CAUSE OF ACTION:

FOR RECOVERY OF PAYMENT ON OPEN BOOK ACCOUNT

(AS AGAINST ALL DEFENDANTS)

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

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

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

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

THIRD CAUSE OF ACTION:

FOR QUANTUM MERUIT

(AGAINST ALL DEFENDANTS)

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

58. As required by law (because the medical services provided were emergency services), the Physician provided surgeries, procedures, medical treatments, and other medical services to the Patient, at the express and/or implied request of the DEFENDANT, thereby benefitting DEFENDANT and the Patient.

59. DEFENDANTS have failed and refused to pay the Physician the appropriate amounts incurred by the Physician in rendering medical services, care, treatment, and/or procedures to the Patient, have underpaid those costs and have failed and refused to pay the usual, reasonable, and customary costs of those services.

60. At all times herein mentioned, DEFENDANTS were required by law to pay usual, reasonable, and customary rates for the emergency care provided by the Physician to the Patient, who were members or subscribers of DEFENDANT. California Health and Safety Code § 1371.4; *Bell v. Blue Cross*, 131 Cal.App.4th 211.

61. DEFENDANT is required to reimburse the Physician at a *quantum meruit* rate for all services rendered to the enrollees, the Patient. The *quantum meruit* amount owed by DEFENDANT to the Physician is determined according to the customary charges that would be billed by the Physician and/or other Physician in the absence of preferred provider or participating provider contractual rates. Based upon DEFENDANTs request that the Physician render treatment, surgeries, procedures and medical services to the Patient, and the fact that DEFENDANT was benefitted by the provision of such services by the Physician, an obligation on the part of DEFENDANT to make restitution to the Physician arose.

62. In *Regents of the University of California v. Principal Financial Group*, 412 F.Supp.2d. 1037, 1042 (N.D. Cal. 2006), the federal trial court held that California law no longer 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,

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

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

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

FOURTH CAUSE OF ACTION:

FOR BREACH OF IMPLIED CONTRACT

(AS AGAINST ALL DEFENDANTS)

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

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

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

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

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

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

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

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

Physician at appropriate rates for the treatment services provided to the Patient.

73. As a result of the foregoing breach, the Physician has been damaged by DEFENDANT in an amount to be determined at trial. Accordingly, there is now due and owing an unpaid sum, plus statutory interest thereon.

PRAYER FOR RELIEF

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

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

DATED: August 16, 2019

Respectfully submitted,

By: A. Nesbit

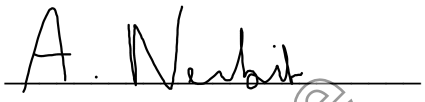
ALAN NESBIT, Esq.
Attorney for Plaintiff
RYAN SPIVAK INTEGRATIVE
PLASTIC SURGERY, INC.

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: 

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