John E. Edwards (SBN 122089)
Law Offices of John E. Edwards
402 West Broadway, Suite 2700
San Diego, California 92101
Telephone: (619) 501-6707
Facsimile: (619) 230-1839

Attorney for Plaintiff Pacific Neurosurgery & Spine Medical Group, Inc.

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN DIEGO, CENTRAL DIVISION

Pacific Neurosurgery & Spine Medical Group, Inc., a California Corporation,

Plaintiff,

v.

Kaiser Foundation Health Plan, Inc., and DOES 1 through 20, inclusive,

Defendants.

Case No. 37-2016-00039067-CU-CO-CTL

COMPLAINT FOR:

1. **Breach of Implied Contract;**
2. **Recovery of Services Rendered - Quantum Meruit;**
3. **Violation of California Health & Safety Code § 1371.75; and**
4. **Violation of California Business & Professions Code § 17200, *et seq.*;**

[IMAGED FILE]

Plaintiff Pacific Neurosurgery & Spine Medical Group, Inc. alleges as follows:

I.

THE PARTIES

1. Plaintiff Pacific Neurosurgery & Spine Medical Group, Inc. ("Plaintiff") is a medical corporation licensed do business and doing business in the State of California, San Diego County. Sanjay Ghosh, M.D. is a shareholder, officer, director and employee of Plaintiff and provides neurosurgical treatment to patients through Plaintiff. Dr. Ghosh is a physician licensed by the State of California and a neurosurgeon, certified by the American Board of Neurological Surgery. Dr. Ghosh has many years of surgical experience as a neurosurgeon performing complex surgeries of the head, neck and skull base. Dr. Ghosh

performs surgical procedures much of which is induced by trauma and requires complicated, expensive, and highly-skilled treatment resulting from a decade of formal education, medical residency and years of medical practice. The complexity of Dr. Ghosh's work is compounded when such services are rendered in an emergency context.

2. Plaintiff is informed and believes, and on that basis alleges, that Defendant Kaiser Foundation Health Plan, Inc. ("Defendant") is a corporation licensed to do business and doing business in the State of California as a provider of medical insurance. Defendant provided medical insurance to and/or was responsible for adjusting claims for benefits for the patient whose medical bills are at issue in this suit.

3. Plaintiff is unaware of the true names and capacities of the defendants sued herein as DOES 1 through 20, inclusive, and therefore sues those defendants by their fictitious names. Plaintiff is informed and believes, and on that basis alleges, that each of the defendants designated herein as a DOE is responsible in some manner for the events and happenings referred to herein, and has proximately caused Plaintiff's damages. Plaintiff will seek leave of court to amend this complaint to more specifically set forth these defendants' wrongful conduct and to identify the capacities in which they acted when that information has been ascertained.

4. Plaintiff is informed and believes, and on that basis alleges, that at all times herein mentioned, defendants, and each of them, were the agents and/or employees of the remaining defendants, and in doing the things complained of herein, were acting within the course and scope of that agency and/or employment and authorized and/or ratified the acts of their co-defendants.

II.

GENERAL ALLEGATIONS

5. California's emergency health care system is dependent upon physicians, especially those with highly sought after specialties such as neurosurgery, agreeing to serve on the staff of hospital emergency rooms and to be on-call in the event that the patients requiring specialized care are admitted to the emergency room. In order for such physicians to continue

to provide emergency health care services, those physicians depend on the prompt and full payment from health insurers for the emergency care that they provide.

6. California law requires that physicians who staff hospital emergency rooms to provide emergency medical services to patients regardless of the patient's insurance status or ability to pay. The physician cannot turn the emergency patient away without service. (See Cal. Health & Saf. Code §1317; *Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211.)

7. Because of the legal requirement that physicians providing emergency room services treat patients regardless of the patient's ability to pay, California law mandates that health plans cover payment for emergency room services provided to its members by out-of-network providers at least until the patient is stabilized. (Cal. Health & Saf. Code §1371.4; *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497, 504; "Subdivision (b) of section 1371.4 was enacted in 1994 to impose a mandatory duty upon health care plans to reimburse non-contracting providers for emergency medical services.")

8. Many insurers maintain networks of preferred providers (also known as "network providers") who they encourage their members to consult through contractual obligations and economic incentives. To become a part of a preferred provider organization ("PPO"), doctors typically sign a contract with a PPO agreeing to provide medical services at a discounted rate to that PPO's members. In return, that PPO seeks to steer its members to physicians in the network, provides advertising and provides various promises regarding timely payment of the medical bills of its members.

9. When a physician signs an agreement with a PPO to accept a discounted rate for providing services to that PPO's members, the physician also agrees not to seek reimbursement of any remaining fees over and above the reimbursement rate provided by that PPO for those services and the co-payment.

10. Out-of-network providers, by contrast, do not have a signed contract with a particular managed care entity and therefore, may collect their full emergency charges directly

from patients at the time of service and are not required to accept reduced rates for procedures performed.

11. Non-contracted medical professionals providing emergency services are entitled to payment of the reasonable value of their services. The California Code of Regulations, Title 28, section 1300.71 mandates that insurers pay at least the usual and customary rate ("UCR") for the services provided. (See *Children's Hospital Central California v. Blue Cross of California* (2014) 226 Cal.App.4th 1260.) Defendants may deny payment only if they reasonably determine that services were never performed. (28 C.C.R. § 1300.71.)

12. Neither Plaintiff nor Dr. Ghosh are contracted with Defendant and all services rendered to the patient whose medical bills are at issue in this case were rendered on an out-of-network basis, and these statutory and regulatory requirements create a quasi contractual relationship between Plaintiff and Defendant.

III

FACTS SPECIFIC TO THIS CASE.

13. This complaint arises out of the failure of Defendant to make payments due and owing to Plaintiff for emergency treatment provided to patient S.F. ("Patient") in January 2015.[1]

14. Plaintiff is informed and believes that Patient is an insured through Defendant.[2] Plaintiff is informed and believes that Patient has health coverage via a valid health maintenance contract with Defendant for the specific purpose of: (l) ensuring that Patient would have access to medically necessary treatment from providers such as Plaintiff; and (2) ensuring that Defendant would pay for the health care expenses incurred by Patient (the "Policy").

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[1] For privacy reasons, the name and specific date of admission of Patient are not set forth herein in full. However, Defendant has identified the Patient via the following claim number(s) for treatments rendered: Claim Numbers X28088791-00, X28088792-00 and X28097665-0. If additional information is required by Defendant to identify Patient and/or the services provided to him by Plaintiff, such information will be disclosed to Defendant upon request.

[2] For privacy reasons, the name of the holder of Patient's insurance policy is being withheld. This information will be disclosed to Defendant upon request.

15. Plaintiff is informed and believes that Defendant received valuable premium payments from the party contracting with Defendant to provide health coverage to Patient.

16. On or about January 2015, Patient suffered a life threatening injury, and was admitted to Scripps Memorial Hospital in La Jolla, California.

17. Plaintiff has agreed to provide neurosurgical services to Scripps Memorial Hospital through an on-call agreement. Dr. Ghosh, an employee of Plaintiff, has staff privileges at Scripps Memorial Hospital and due to his expertise in neurosurgery, he was called in to provide emergency neurosurgical services on Patient.

18. Dr. Ghosh performed emergency surgery on Patient. Thereafter, Plaintiff billed Defendant a total of $88,200 for services related to the surgery performed by Dr. Ghosh on Patient, who is Defendant's insured. That sum represents the reasonable value of the emergency services provided to Patient.

19. To date, Defendant has paid a total of just $27,835.21 to Plaintiff for the medical services provided by Dr. Ghosh to Patient.

20. Defendant has since refused to pay, and continues to refuse to pay Plaintiff any additional monies in connection with the medically necessary emergency services rendered to Patient by Dr. Ghosh.

21. Defendant is required under California law to reimburse emergency medical claims by paying "reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually...." 28 C.C.R. §1300.71(a)(3)(B).

22. Plaintiff is informed and believes, and on that basis alleges, that Defendant did not comply with this obligation to obtain current data updated annually. Dr. Ghosh believes that reimbursement determinations and dispersals were made without compliant and valid data to substantiate its determinations. As a result, Dr. Ghosh was underpaid for his emergency medical services provided to Patient, Defendant's member.

23. Defendant has breached its obligation to reimburse Dr. Ghosh for his emergency medical claims rendered to Patient and has violated California law.

24. Defendant receives money from its members to be used to pay for medical services rendered to its members. As a condition of being able to write health policies in California, Defendant is obligated to pay for emergency medical services incurred by its plan members, and to pay emergency medical professionals, like Dr. Ghosh, the reasonable value of the medical services provided.

25. Nevertheless, Plaintiff is informed and believes, and on that basis alleges, that Defendant pays non-contracting emergency doctors, including Dr. Ghosh, arbitrary amounts that are substantially below the reasonable value of the services rendered, in violation of California law. Defendant has paid Plaintiff only a fraction of the reasonable value of the emergency medical services rendered by Plaintiff to Patient. Defendant has thus benefitted significantly from the provision of emergency medical services to Patient.

26. Plaintiff has been and continues to be adversely affected by Defendant's business practices as alleged herein in that Defendant has paid Plaintiff less than it is entitled to receive for services rendered, thereby enriching Defendant to the detriment of Plaintiff.

FIRST CAUSE OF ACTION
For Breach of Implied Contract
(Against All Defendants)

27. Plaintiff incorporates all allegations set forth in the above paragraphs 1 through 26 as though fully set forth herein.

28. Under California law, including Health & Safety Code section 1371.4, Defendant was and is required to reimburse Plaintiff for emergency medical services rendered by Dr. Ghosh to Defendant's members.

29. Plaintiff is informed and believes and thereon alleges that, at all relevant times herein, Patient had a valid policy with Defendant.

30. Plaintiff is informed and believes that Patient obtained such a policy with Defendant for the specific purpose of: 1) ensuring that Patient would have access to medically necessary treatment and emergency room services at health care facilities like Scripps Memorial Hospital and would have access to emergency treatment of the type provided by Plaintiff; and (2) ensuring that Defendant would pay for the health care expenses incurred by

Patient. Defendant knew or reasonably should have known that any insured would seek necessary emergency medical treatment at the hospital in closest proximity to them, such as Patient did with Scripps Memorial Hospital, and that Scripps Memorial Hospital would utilize the medical services of expert physicians such as Dr. Ghosh.

31. Plaintiff is informed and believes that Defendant received, and continues to receive, valuable premium payments from Patient under the Policy.

32. By virtue of the obligations imposed by California Health & Safety Code section 1371.4, there exists and existed an implied-in-law contract between Plaintiff and Defendant when Dr. Ghosh provided emergency medical services to Patient at Scripps Memorial Hospital. This implied-in-law contract requires Defendant to reimburse Plaintiff for emergency medical services rendered to Patient, and pay Dr. Ghosh's full, reasonable and customary value of those services.

33. The reasonable value of the medical services provided by Plaintiff to Patient is $88,200.

34. Despite Defendant's obligation to reimburse Plaintiff, Defendant has refused to pay and continues to refuse to pay Plaintiff for the whole of the sums owed to Plaintiff for the treatment services provided to Patient.

35. As a result of the foregoing breach, Plaintiff has been damaged by Defendant in an amount in excess of $60,364.79 to be proven at trial.

SECOND CAUSE OF ACTION
For Recovery of Services Rendered - Quantum Meruit
(Against All Defendants)

36. Plaintiff incorporates all allegations set forth in the above paragraphs 1 through 35 as though fully set forth herein.

37. The California Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene Act") provides that "a health care service plan shall reimburse providers for emergency services and care provided to its enrollees." (Cal. Health & Saf. Code §1371.4 (b). Section 1371.4 further provides that "payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were

never performed. . . ." (*Id.* at 1371.4(c).)

38. The Knox-Keene Act defines emergency services and care as:

> [M]edical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition ... exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

(Cal. Health & Saf. Code §1317.1(a)(l).)

39. The Knox-Keene Act defines emergency medical condition as:

> A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) Placing the patient's health in serious jeopardy[;] (2) Serious impairment of bodily functions[; or] (3) serious dysfunction of any bodily organ or part.

(Cal. Health & Saf. Code §1317.1(b).)

40. The Knox-Keene Act further provides that in the case of a disagreement between a managed care payor and a health care provider over a patient's post-stabilization care following the occurrence of an emergency medical condition:

> [T]he plan shall assume responsibility for the care of the patient by having medical personnel contracting with the plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the plan agree to accept the transfer of the patient ... If the health care service plan fails to satisfy the requirements of this subdivision, further necessary care shall be deemed to have been authorized by the plan. Payment for this care may not be denied.

(Cal. Health & Saf. Code §1371.4(d) [emphasis added].)

41. Under California law, Scripps Memorial Hospital is required to provide emergency room services to all individuals who present themselves at Scripps Memorial Hospital's emergency room, such as Patient, and Defendant is required to pay for emergency room services for their members. As a member of Scripps Memorial Hospital's medical staff,

and as a preeminent neurosurgeon, Dr. Ghosh was obligated, legally, professionally, and morally, to provide emergency medical care to Patient.

42. Plaintiff rendered emergency medical services to Patient, who is insured with Defendant. Defendant knew these services were being provided to their insured, Patient, and did not contest these services being provided. Patient accepted each of the services provided by Plaintiff.

43. Plaintiff has demanded that Defendant pay for the emergency medical treatment provided to Patient, and has submitted statements to Defendant for the emergency services rendered to Patient.

44. Under California law, Defendant is required to reimburse Plaintiff at a quantum meruit rate for all emergency services rendered to its enrollees. The quantum meruit amount is determined according to the full reasonable and customary charges that would be billed by Plaintiff in the absence of contractual rates.

45. The quantum meruit rate for the medical treatment Plaintiff provided to Patient is $88,200.

THIRD CAUSE OF ACTION
For Violation of California Health & Safety Code section 1371.35

46. Plaintiff incorporates all allegations set forth in the above paragraphs 1 through 45 as though fully set forth herein.

47. The Knox-Keene Act further requires that "[a] health care service plan, including a specialized health care service plan, shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the complete claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the complete claim by the health care service plan." (Cal. Health & Safety Code §1371.35(a).) Alternatively, "a plan may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health

care service plan, or if the health care service plan is a health maintenance organization, working days after receipt of the claim by the health care service plan." (*Id.*)

48. As alleged herein, Defendant violated California Health and Safety Code section 1371.35 by their actions which include, but are not limited to, failing to reimburse Plaintiff for Patient's medically necessary surgical services within 45-working days after receipt of the claim.

49. As a direct and proximate result of Defendant's wrongful conduct as alleged herein, Plaintiff is entitled to the greater of $15 per year per claim or interest at the rate of 15% per claim beginning with the first calendar day after the 45-working-day period. (Cal. Health & Safety Code §1371.35 (b).)

FOURTH CAUSE OF ACTION
For Violation of Cal. Bus. & Prof. Code § 17200, *et seq.*
(Against All Defendants)

50. Plaintiff incorporates all allegations set forth in the above paragraphs 1 through 49 as though fully set forth herein.

51. By their wrongful conduct as set forth above, Defendant engaged in unfair business acts or unfair business practices in violation of California Business and Professions Code section 17200, *et seq.* Defendant violated the Knox-Keene Act, including but not limited to: California Health and Safety Code sections 1371, 1371.1, 1371.4, 1371.35 and 1371.37; California Code of Regulations, title 28, sections 1300.71 and 1300.71.38; California Insurance Code sections 790.03, 880 and 10123.13, and 10 C.C.R. 2695.1 – 2695.7 and 2695.11 – 2695.12. Through the acts set forth in this Complaint, Defendant has engaged in a pattern of unlawful business practices.

52. The Knox-Keene Act provides that a "health care service plan is prohibited from engaging in an unfair payment pattern." The Act defines an unfair payment pattern to include "[e]ngaging in a demonstrable and unjust pattern, as defined by the department, of reducing the amount of payment or denying complete and accurate claims." (Cal. Health & Saf. Code §1371.37(c)(2).)

53. Defendant has engaged in unfair and/or unlawful acts and practices by inter alia, failing to comply with Health and Safety Code §§1371, *et seq.*, by knowingly, among other things, engaging in an "unfair payment pattern" by failing to pay Plaintiff for emergency services provided to Patient.

54. Defendant's conduct threatens and/or constitutes violations of the letter, policy or spirit of the above mentioned laws and regulations.

55. As a result of the conduct described above, Defendant has received and retained sums that rightfully belong to Plaintiff.

56. Plaintiff is entitled to restitution in the amount of $60,364.79, plus statutory interest, which is the amount that Defendant is obligated to pay Plaintiff for the services its employees provided to Patient.

WHEREFORE, Plaintiff prays for judgment against Defendant as follows:

1. For compensatory damages in an amount to be proven at trial;
2. For restitution in an amount in excess of $60,364.79, to be proven at trial;
3. For prejudgment interest;
4. For all attorney's fees and costs incurred herein; and
5. For such other relief as the court deems just and proper.

Law Offices of John E. Edwards

Dated: 11/3/16

John E. Edwards
Attorney for Plaintiff
Pacific Neurosurgery & Spine Medical Group, Inc