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Prime Healthcare Foundation – Southern Regional, LLC d.b.a Southern Regional Medical Center

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

PRIME HEALTHCARE FOUNDATION, INC., a Delaware corporation, and PRIME HEALTHCARE FOUNDATION-SOUTHERN REGIONAL LLC; dba SOUTHERN REGIONAL MEDICAL CENTER;

Plaintiff

vs.

AETNA LIFE INSURANCE CO. a Connecticut Corporation; and DOES 1 through 50, Inclusive.

Defendants.

Case No.

COMPLAINT FOR:

1. BREACH OF IMPLIED – IN – LAW CONTRACT – EMERGENCY CLAIMS

2. BREACH OF IMPLIED – IN – FACT CONTRACT – POST – STABILIZATION CLAIMS

3. DECLATORY RELIEF

DEMAND FOR JURY TRIAL

Plaintiff Prime Healthcare Foundation, Inc. and Prime Healthcare Foundation – Southern Regional LLC; dba: Southern Regional Medical Center(hereinafter collectively as "PHSI") alleges against Defendant Aetna Life Insurance Company as follows:

I.

JURISDICTION AND VENUE

1. This Court is the proper venue for this action pursuant to 28 U.S.C § 1391(b) because a substantial part of the events or omissions giving rise to the claims alleged herein occurred in this Judicial District, and because one or more of the Defendants conducts a substantial amount of business in this Judicial District.

II.

THE PARTIES

2. Prime Healthcare Foundation, Inc. is a California based company located in Ontario, California. Prime Healthcare Foundation, Inc. is the sole shareholder or member of corporations or limited liability companies that owns 11 hospitals, including Prime Healthcare Foundation-Southern Regional LLC; dba Southern Regional Medical Center. Prime Healthcare Foundation, Inc. is one of the largest minority owned businesses in the State of California.

3. Prime Healthcare Foundation-Southern Regional LLC; dba Southern Regional Medical Center ("Southern Regional") is a hospital that provides healthcare services to patients, including Defendants' members. Southern Regional is, and at all relevant times was a Delaware corporation organized and existing under the laws of Delaware with its principal place of business in Riverdale, Georgia. Southern Regional is, and at all relevant times was, a hospital and healthcare provider licensed and in good standing under the laws of Georgia.

4. PHSI is informed and believes that Defendant Aetna Life Insurance Co., ("Aetna") is a corporation duly organized and existing under the laws of Connecticut and is authorized to transact the business of insurance in both Georgia and California. PHSI is informed and believes that Aetna's principal place of business is 151 Farmington Ave., RW61, Hartford, CT, 06156.

5. The true names and capacities of the defendants named herein as Does 1 through 50, inclusive, whether individual, corporate, associate, or otherwise are currently unknown to

1 Plaintiff and therefore Plaintiff alleges that each of the fictitiously named defendants is
2 responsible in some manner for the events sued upon. Plaintiff will seek leave of this court to
3 amend the complaint to assert the true names and capacities of the defendants named herein as
4 Does 1 through 50, inclusive, when said names and capacities have been ascertained. Aetna and
5 Does 1 through 50 will collectively be referred hereto as "Defendants."

6 6. All billing for medical services rendered, including medical billing coding, is prepared in
7 Ontario, California. All medical billing is remitted from Ontario, California. All correspondence
8 relating to insurance billing from Plaintiffs originates in Ontario, California, and all "explanation
9 of benefits" correspondences, or other similar responsive correspondence from insurance carriers
10 is received and reviewed in Ontario, California. All administrative appellate correspondence and
11 other such pre-litigation correspondence to insurance carriers is prepared in Ontario, California.
12 Thus, in summary, every aspect of the medical billing process and response to medical billing
13 process for all claims which are the subject of this lawsuits originate in Ontario California.

14 **III.**

15 **AGENCY**

16 7. PHSI is informed and belies that Defendants are the agents of each other, and of the Self-
17 Insured and have actual or ostensible authority, to act on each other's behalf, and on behalf of the
18 Self-Insured for: (a) certifying or authorizing PHSI's provision of services to members; (b)
19 receiving PHSI's claims; (c) pricing the claims; (d) processing and administering the claims and
20 appeals; (e) approving or denying the claims; (f) deciding not to transfer the members to in-
21 network hospitals for post-stabilization Services; (g) authorizing PHSI to provide post
22 stabilization Services to Defendants' members; (h) directing whether and how to pay the claims;
23 (i) issuing remittance advices and explanations of benefits; (j) communicating with PHSI
24 regarding the claims and Services; (k) communicating with members regarding the claims and
25 Services; (l) providing utilization management Services; and (m) in many instances issuing
26 payment. With respect to every claim at issue in this case regardless of whether the claim is
27 responsibility of Defendants, PHSI dealt directly with Defendants as an indistinguishable entity.
28

PHSI submitted reimbursement claims to Defendants, communicated about the claims with Defendants, and *received payments* from Defendants.

8. PHSI is informed and believes that, as the appointed agents of the Self-Insured, Defendants are in possession of all facts, information and data concerning and related to the authorization, processing, pricing, and payment of all claims submitted by PHSI to the aforementioned Defendants.

IV.

ASSIGNMENT AND STANDING

9. As a condition of admission, each patient at PHSI signs a Conditions of Admission form agreeing to, *inter alia*, assign his or her health insurance benefits to PHSI. Each assignment of benefits provides for PHSI to be paid directly for the services provide to the patient.

10. PHSI received an assignment of benefits for every claim at issue in this litigation. PHSI maintains each patient's assignment of benefits in the patient's hospital records. PHSI's Assignment of Insurance Benefits reads as follows:

> The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to any hospital-based physician of any insurance of health plan benefits otherwise payable to or on behalf of the patient for professional services rendered during this hospitalization of for outpatient service, including emergency services if rendered, at a rate not to exceed such physician's regular charges. It is agreed that payment to such physician pursuant to this authorization by an insurance company or health plan shall discharge said insurance company of health plan of any and all obligation under the policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

11. Upon discharge of each patient, PHSI computerized billing system generates an itemized list of services and products used to deliver care to the patient. From this list, PHSI generates a standardized bill on the national industry standard UB-04 form used to bill insurance payors. Defendants were each individually notified of their respective patients' assignments of benefits directly on each UB-04 bill they received from PHSI in connection with each claims at issue in this case.

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V.

ALLEGATIONS COMMON TO ALL CLAIMS

12. It is standard practice in the health care industry that when a hospital such as PHSI, enters into a written contract with a health plan, such as Defendants, the hospital agrees to accept reimbursement that is discounted from the hospital's billed charges in exchange for the benefits of being a "contracted provider" (*i.e.*, a provider with a written contract with the plan). These benefits include an increased volume of business because the health plan provides financial and other incentives for its members to receive their medical care at the contracted provider, advertises that the provider is "in-network", and allows members to pay lower co-payments and deductibles to use the contracted provider for their non-emergency services.

13. Another benefit to the health plans of these written agreements is that the hospitals agree not to bill the health plans' members for contracted services, except for co-payments and deductibles.

14. Conversely, when a hospital, such as PHSI, does not have a written contract with a health plan, the hospital receives less business from the plan, as the health plan discourages its members from receiving their non-emergency care at the out-of-network provider. As a result, the non-contracted hospital has no obligation to reduce its charges or offer a discount, and is entitled to receive payment based on its charges for services rendered. The health plan is not entitled to a discount from the hospital's total billed charges because it is not providing the hospital with the benefits of an increased patient volume that results from being an in-network provider.

15. In recent years, Defendants' contracts have demanded such low rates and have become so onerous and one-sided in favor of Defendants, that many hospitals like PHSI, have determined that they cannot afford to enter into such contracts with Defendants. As a result, a growing number of hospitals have become "non-contracted" or "out-of-network" with Defendants.

16. In these non-contracted situations, Defendants have drastically underpaid hospitals for the medically necessary Services they have provided to the members of Defendants, who have contracted with Defendants to price and administer their healthcare claims. Defendants have used flawed methodologies to unilaterally determine what amounts hospitals should charge for

1 their services. These flawed methodologies fail to comply with the provisions of members'
2 insurance contracts, Summary Plan Descriptions ("SPDs"), or Evidence of Coverage ("EOCs")
3 for calculating payments to non-contracted hospitals, do not comply with legal standards and
4 generally accepted industry standards for calculating payments to non-contracted hospitals, and
5 result in payments which are not reasonable and do not adequately reimburse non-contracted
6 hospitals for the medically necessary services they provide to Defendants' members. Instead,
7 these flawed methodologies unfairly and illegally shift the burden and expense of payment for
8 emergency and post-stabilization healthcare services to patients, and force non-contracted
9 hospitals to balance bill their patients for sums which are legally owed by Defendants.

10 **DEFENDANTS' FAILURE TO OFFER PHSI FAIR AND REASONABLE RATES**

11 17. PHSI attempted to negotiate rates with Defendants. As it has done with other hospitals in
12 California and Georgia, however, Defendants would not offer PHSI fair and reasonable rates.

13 18. Health and Safety Code § 1367(h) provides that "contracts with providers, and other
14 persons furnishing services, equipment, or facilities to or in connection with the plan, shall be
15 fair, reasonable, and consistent with the objectives of this chapter."

16 19. Insurance Code § 10133.5 provides that, "to ensure that insureds have the opportunity to
17 access the opportunity to access needed health care Services in a timely manner." Health plan
18 contracts must not be "inconsistent with standards of good health care and clinically appropriate
19 care," and that "[a]ll contracts, including contracts with providers and other persons furnishing
20 Services, or facilities shall be fair and reasonable."

21 20. Rather than offering fair and reasonable rates to PHSI, Defendant would only agree to
22 extremely low rates which were "inconsistent with standards of good health care and clinically
23 appropriate care". PHSI could not afford to accept such low rates and provide good quality
24 health care to its patients.

25 21. Rather than paying PHSI's claims based on its full billed charges from September 2012
26 to the present, Defendants instead underpaid PHSI's claims by erroneously applying a flawed,
27 secret and legally inappropriate UCR analysis to many of the claims.
28

1 22. Defendants' systems for paying out-of-network claims are flawed. Defendants
2 improperly manipulate the data in its systems to calculate incorrect and inappropriately low
3 reimbursement amounts for non-contracted hospital claims, and Defendants' systems and
4 methods for calculating the rates for non-contracted providers violates the provisions of the
5 members' insurance policies and California law.

6 23. PHSI continued to provide medically necessary emergency and non-emergency health
7 care to patients with valid insurance policies with Defendants. In the case of emergency medical
8 Services, PHSI was legally obligated to provide such Services in accordance with state and
9 federal law. On behalf of itself, or as the appointed agent of Defendants authorized PHSI to
10 provide the non-emergency Services rendered to Defendants' members.

11 **THE FLAWED DEFENDANTS' DATABASE**

12 24. For many claims, Defendants have represented that it uses an internal database of claims
13 to calculate a "customary and reasonable" reimbursement rate to the hospital. For other claims,
14 Defendants have represented that it "implemented the use of Usual and Customary rates, based
15 on the procedure and the geographic location." And in other instances, Defendants have filed
16 altogether to explain the basis for underpaying claims.

17 25. The claims submitted by PHSI to Defendants for pricing and payment were required to be
18 paid at a rate that is referred to interchangeably in the industry and in the Defendants' own plan
19 documents as the "Usual, Customary and Reasonable" rate, the "Reasonable and Customary"
20 amount, the "Usual and Customary" amount, the "Reasonable Charge", the "Prevailing Rate",
21 the "Usual Fee", the "Competitive Fee", or some other similar phrase that, in the context of the
22 health industry, means the same thing. The industry shorthand for these terms is "UCR", and
23 herein after "UCR" shall refer to and incorporate these phrases.

24 26. PHSI is informed and believes that Defendants' methodology and systems for
25 determining UCR and paying out-of-network hospital claims are flawed, that Defendants
26 improperly manipulate the data in its systems to calculate incorrect and inappropriately low
27 amounts in paying hospital claims, and that Defendants' systems and methods for calculating the
28 UCR rates for non-contracted providers violates the members' policies and California law.

27. The UCR amount is properly determined based on a review of the prevailing or competitive charges for similar healthcare Services by similar types of providers within the same geographic area at the time. However, for years Defendants, on behalf of themselves have systematically failed to properly price the claims according to UCR, and have systematically concealed this failure, through misrepresentations and concealments about their pricing and payment methods.

MEDICALLY NECESSARY SERVICES PROVIDED TO DEFENDANTS' MEMBERS AND BENEFICIARIES

28. PHSI provided medically necessary emergency and non-emergency Services to member of the health plans of Defendants.

29. PHSI was and is obligated to provide emergency Services to each Defendants' members. PHSI was and is also obligated to not abandon patients requiring "post-stabilization Services" (*i.e.*, Services after a patient's emergency medical condition is stabilized) if Defendants chose not to transfer their members to contracted hospitals.

30. For the claims at issue in this litigation, Defendants paid PHSI improperly at rates that are well below the UCR rate, even though they were no longer entitled to pay PHSI's claims at discounted rates.

31. For the patient claims at issue, PHSI provided medical Services to Defendants' members, including but not limited to emergency Services, inpatient Services following admission from PHSI's emergency room and outpatient Services.

32. For all patients' claims at issue, PHSI confirmed that the patient was an eligible member of one of one of the Defendants' plans by contacting Defendants either by phone, fax, or an online insurance verification service. PHSI contacted Defendants concerning stabilized emergency room patients who required further post-stabilization care to verify benefits and request authorization to provide post-stabilization care. PHSI is informed and believes that the number provided on the patients' identification cards is Defendants' telephone number, and therefore the representatives who answer PHSI's calls are Defendant's employees. PHSI is

informed and believes that responding to requests for verification of benefits and requests for authorization is one of the administrative Services that Defendants provide.

33. With respect to every patient whose claim is at issue in this case (except for emergency room patients for whom no authorization need be sought), PHSI called Defendants to request authorization for the Services. In each and every case in which PHSI made such call, Defendant, on behalf of themselves either informed PHSI that no formal authorization was necessary, or authorized PHSI to provide the Services to the members.

34. With respect to each patient, PHSI obtained an assignment of benefits, which provides as follows:

> The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to any hospital-based physician of any insurance of health plan benefits otherwise payable to or on behalf of the patient for professional Services rendered during this hospitalization of for outpatient service, including emergency Services if rendered, at a rate not to exceed such physician's regular charges. It is agreed that payment to such physician pursuant to this authorization by an insurance company or health plan shall discharge said insurance company of health plan of any and all obligation under the policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

35. With respect to every claim at issue in this litigation, after providing the medically necessary service, PHSI timely submitted the appropriate claim forms for payment to Defendants. The claim forms include information such as type of procedure, the coding for the procedure, the fact that PHSI received an assignment of health care benefits from the member, and other information by which the claim can be identified, processed and paid. The claim form also includes PHSI's usual and customary billed charges. As set forth above, those charges are submitted on industry standard forms, commonly known as Uniform Billing ("UB") forms.

36. As is standard in the industry, the "charges" indicated by PHSI on the UB are the same regardless of whether the payor is a private or public entity, contracted or non-contracted, or an individual person.

A.

EMERGENCY SERVICES

37. Under the federal Emergency Medical Treatment and Active Labor Act ("EMTALA"), Social Security Act § 1867(a), and California Health and Safety Code § 1317, individuals who believe that they are suffering a medical emergency have the right to seek treatment at the nearest emergency room, and hospitals which have emergency rooms, including PHSI, have a statutory duty to provide emergency Services and care to all individuals regardless of the patients ability to pay or their possession or type of insurance benefits.

38. Therefore, by law, when a member of any Defendants present themselves to PHSI's emergency room, PHSI is legally obligated to treat that person without regard to the person's ability to pay and without first obtaining insurance verification or authorization to provide the treatment. PHSI cannot refuse to provide emergency treatment to one of Defendants' members simply because Defendants are non-contracted with PHSI and the individual does not have the personal resources to pay for such emergency care.

39. PHSI is informed and believes that the health care benefits plans, SPDs, EOCs or policies of Defendants' require each of the Defendants to pay a reasonable and customary rate for emergency medical care.

40. After PHSI obtained an assignment of benefits, it provided medically necessary emergency care required by member of Defendants.

41. PHSI performed duties that are the responsibility of Defendants by providing medical care to their respective members that was immediately necessary to prevent serious bodily harm to or suffering by these members. PHSI provided these immediately necessary medical Services with the intent to charge its customary rates for its Services.

42. PHSI's billed charges are reasonable and customary. Even though it is a leading hospital in the United States, PHSI's charges are comparable to other hospitals in its geographic area and other hospitals that provide the same quality of Services. PHSI has a stellar reputation and provides high quality care. PHSI's charges are competitive with other comparable hospitals in Southern California that provide the same sophistication and quality of Services. Compared to

other similar quality hospitals in the area, and compared to other hospitals that have comparable reputations and offer comparable high quality Services, PHSI's charges are reasonable and customary for non-contracted Services.

43. Members of Defendants sought emergency treatment at PHSI for various serious and emergent injuries. PHSI is informed and believes that, due to the unpredictable nature of emergency care claims, every day that PHSI and Defendants remain "out of contract", members of every Defendant will continue to arrive at PHSI's emergency department in need of emergency treatment.

44. After PHSI provided emergency care to Defendants' members, PHSI promptly submitted claim information to Defendant, for itself or as the appointed agent, to be processed for payment.

45. Defendant have failed to properly reimburse PHSI for emergency health care provided to their respective members.

46. In many cases, Defendants paid PHSI based on 100% of its billed charges. Such payments, while not at issue in this litigation, demonstrate recognition that PHSI's billed charges are reasonable and customary.

47. In many other cases, Defendants have paid PHSI's claims far less than is due under the terms of patient's SPD or EOC. As stated above, PHSI's charges are reasonable and customary. PHSI is informed and believes that Defendants have paid PHSI's claims at inappropriately low rates because they have used Defendants' illegal and flawed databases and systems for calculating reimbursement to non-contracted hospitals.

48. Furthermore, PHSI is informed and believes that many of the plans at issue have varying reimbursement percentage depending upon whether the patient chose to receive their care at a non-contracted hospital.

49. For many of the claims at issue herein, Defendants have inappropriately paid emergency claims under their respective plans as though the member voluntarily chose to receive the emergency care at a non-contracted hospital (PHSI). In addition, in many instances, they have improperly applied out-of-network benefits when the member did not "choose" to go out of network, and systematically reduced benefits paid to PHSI.

FIRST CAUSE OF ACTION

Breach of Implied-in-Law Contract – Emergency Claims

(Against All Defendants)

50. The allegations set forth above are hereby incorporated as if fully set forth herein.

51. Federal and state laws support an implied-in-law contract whereby PHSI was legally required to provide emergency Services and care to the members, upon which Defendants became legally required to pay PHSI directly for such Services rendered to their respective members.

52. Under EMTALA and California Health and Safety Code § 1317, PHSI is required to provide emergency Services and care to all individuals, including members of Defendants, who present themselves at its emergency department with potentially life-threatening conditions, without regard to the patients' ability to pay or their possession of insurance benefits.

53. Therefore, by law, when a member or insured of a Defendants presents himself or herself to PHSI's emergency room, PHSI must treat that individual without regard to the person ability to pay and without first obtaining insurance verification or authorization to provide the treatment.

54. Due to the unpredictable nature of emergency care, Defendants' members continue to arrive at PHSI's emergency department in need of emergency treatment every day.

55. As set forth above, PHSI obtained an assignment of benefits from each of Defendants' members to whom it provided medical Services requiring the applicable Defendant to pay PHSI directly for Services rendered.

56. After it provided emergency care to each Defendants' respective members, PHSI promptly submitted claim information to Defendants, as directed on the patients' insurance identification cards, to be processed for payment.

57. PHSI has a common law *quantum meruit* right to receive payment from third parties (like Defendants) who are responsible for paying for the Services provided to their members. Restatement of Restitution § 114, entitled the "Performance of Another's Duty to a Third Person in an emergency", provides as follows:

> A person who has performed the duty of another by supplying a third person with necessaries, although acting without the other's knowledge or consent, is entitled to restitution for the other therefor if:
>
> (a) he acted unofficiously and with to charge therefor, and
>
> (b) the things or Services supplied were immediately necessary to prevent serious bodily hard to or suffering by such person

58. PHSI has provided emergency Services and care to patients who are members of Defendants and intended to charge for the care provided. PHSI's Services were immediately necessary to prevent serious bodily harm to or suffering by such person.

59. PHSI is informed and believes that these members pay premiums to the applicable Defendant in return for coverage under a healthcare service plan that includes coverage for emergency Services and care. Accordingly, in providing emergency Services and care to each of Defendants' respective members, PHSI intended to and has conferred a benefit on each Defendant. PHSI provided such Services with the reasonable expectation of full payment for its Services directly from the applicable Defendants.

60. PHSI performed duties that are the responsibility of each Defendant by providing emergency medical care to their members. PHSI provided these immediately necessary medical Services unofficiously with the intent to charge its customary rates for its Services.

61. Defendants have failed to pay PHSI directly for such Services.

62. Accordingly, there is due, owing and unpaid from Defendants to PHSI, an amount to be proven at trial, of no less than $100,000.00, plus applicable statutory interest.

SECOND CAUSE OF ACTION

Breach of Implied-In-Fact Contract – Post-Stabilization Claims

(Against All Defendants)

63. The allegations set forth above are hereby incorporated as if fully set forth herein.

64. For all patients' claims at issue, PHSI confirmed that the patient was an eligible member of one of the Defendants' plans by contacting Defendant, either by phone, fax, or an online insurance verification service. As alleged above, PHSI also contacted Defendants concerning

1 emergency room patients who require further post-stabilization care to request authorization to
2 provide post-stabilization care.
3 65. In emergency situations, PHSI is legally obligated to provide patients with the medically
4 necessary healthcare Services they need even without such verification, and Defendants are
5 legally obligated to pay PHSI for the emergency care provided to their members.
6 66. The conduct between PHSI and Defendants created an implied-in-fact contract whereby
7 PHSI agreed to provide post-stabilization Services to the Defendants' members, and Defendants
8 agreed to pay PHSI for such Services.
9 67. In all cases where Defendants' members required post-stabilization care, Defendants
10 chose not to transfer the patient from PHSI to another hospital, but instead requested that PHSI
11 provide the post-stabilization care. By requesting that PHSI provide post-stabilization care to
12 their members and insureds, and by authorizing PHSI to provide such Services, Defendants
13 entered into implied-in-fact contracts with PSHI whereby Defendants requested that PHSI
14 provide the post-stabilization care to the members and insureds, and Defendants agreed to
15 reimburse PHSI for the post-stabilization Services at PHSI's regular billed charges.
16 68. At the time that Defendants decided not to transfer the post-stabilization patients to other
17 hospitals, they knew of the rates that PHSI charges for its Services. PHSI's charges are publicly
18 available on OSHPD's website, and Defendants have received, and were continuously receiving
19 PHSI's claims which contained the rates that PHSI charged for its various Services. If
20 Defendants did not want to pay the rates that PHSI charged for its Services, they could have, and
21 should have, transferred the post-stabilization patients to contracting hospitals. Having chosen
22 not to transfer the patients to in-network hospitals, Defendants agreed to pay PHSI at the rates it
23 charges for its Services.
24 69. Defendants' payment of any amount is an acknowledgment by the Defendants of their
25 responsibility under an implied-in-fact contract to reimburse PHSI for the post-stabilization
26 Services provided to their members and insureds. Defendants' unilateral determinations to
27 reimburse PHSI less than its billed charges are improper. Defendants continue to breach the
28 implied contracts by delaying payment, reducing payment and denying payment to PHSI for

medical treatment provided to Defendants' members and insureds in an amount to be proven at trial.

THIRD CAUSE OF ACTION

For Declaratory Relief

(Against All Defendants)

70. PHSI incorporates all allegations set forth in the above paragraphs as though fully set forth herein.

71. A controversy has arisen between Defendants and PHSI as to the methodology used by Defendants to calculate the UCR rate for Services rendered by PHSI to Defendants' members.

72. As explained in detail above, PHSI is informed and believes that Defendants' methodology and systems for determining the UCR and paying out-of-network hospital claims are flawed, and inconsistent with the industry-standard UCR definitions set forth in the applicable plans, EOCs, and SPDs.

73. Accordingly, PHSI seeks a declaration that:

a. Defendants' methodology for pricing out-of-network claims does not comply with the provisions of the controlling SPDs or ECOs, standards established under California law and the law of other jurisdictions, or generally accepted methods for calculating UCR.

b. Defendants failed to pay reasonable and customary charges for PHSI's emergency claims.

c. Defendants owe PHSI its full-billed charges for post-stabilization claims.

d. Defendants must reimburse PHSI directly for its emergency and post-stabilization claims and cannot pay patients instead.

e. Defendants are obligated to pay PHSI's full billed charges for post-stabilization in situations where Defendants have chosen not to transfer their members to other hospitals after being notified by PHSI about the stabilization of their members.

f. Defendant will not continue to use an improper method to determine reasonable and customary rates to reimburse PHSI with respect to future claims.

WHEREFORE, PHSI prays for judgment against Defendants as follows:

1. For damages in an amount to be proven at trial, of no less than $100,000.00 plus all applicable interest allowed at law;
2. For restitution in an amount to be proven at trial, plus applicable interest allowed at law;
3. For all attorneys' fees and costs incurred in bringing this action, to the extent recoverable by law;
4. For declaratory relief;
5. For injunctive relief; and
6. For such other relief as the Court deems just and appropriate.

TROY A. SCHELL, ESQ.
BRYAN WONG, ESQ.

Dated: June 3, 2016

By: /s/ Bryan Wong
Bryan Wong
Attorneys for Plaintiff

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