DEVIN M. SENELICK (State Bar No. 221478)
ERIC D. CHAN (State Bar No. 253082)
HOOPER, LUNDY & BOOKMAN, P.C.
1875 Century Park East, Suite 1600
Los Angeles, California 90067-2517
Telephone: (310) 551-8111
Facsimile: (310) 551-8181
E-Mail: echan@health-law.com

Attorneys for Dr. Michael Jadali, Center For Pain & Rehabilitation Medicine, and Pacific Coast Medical Clinic

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SANTA CLARA

DR. MICHAEL JADALI, D.O., CENTER FOR PAIN & REHABILITATION MEDICINE, a California corporation, and PACIFIC COAST MEDICAL CLINIC, a California corporation,

Plaintiffs,

vs.

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Connecticut corporation; CIGNA HEALTHCARE OF CALIFORNIA, INC., a California corporation, DOES 1 through 50, Inclusive,

Defendants.

Case No.

COMPLAINT FOR:

1. **BREACH OF IMPLIED IN FACT CONTRACT**
2. **BOOK ACCOUNT**
3. **UNFAIR BUSINESS PRACTICES**
4. **INTENTIONAL INTERFERENCE WITH PROSPECTIVE ECONOMIC ADVANTAGE**
5. **NEGLIGENT INTERFERENCE WITH PROSPECTIVE ECONOMIC ADVANTAGE**
6. **INTENTIONAL INTERFERENCE WITH PROSPECTIVE ECONOMIC ADVANTAGE**
7. **NEGLIGENT INTERFERENCE WITH PROSPECTIVE ECONOMIC ADVANTAGE**

DEMAND FOR JURY TRIAL

Trial Date: None Set

HOOPER, LUNDY & BOOKMAN, P.C.
1875 CENTURY PARK EAST, SUITE 1600
LOS ANGELES, CALIFORNIA 90067-2517
TEL.: (310) 551-8111 • FAX: (310) 551-8181

Plaintiffs Dr. Michael Jadali, Center for Pain & Rehabilitation Medicine ("CPRM"), and Pacific Coast Medical Clinic (together, "Plaintiffs") and hereby complain and allege as follows:

1. This lawsuit arises out of Defendants' concerted campaign of economic warfare against Plaintiffs.

2. Plaintiffs were in-network healthcare providers with Cigna for many years. After Plaintiffs ceased being in-network in 2014, however, Cigna began targeting Plaintiffs' business in a variety of ways that have caused significant and ongoing harm.

3. Almost immediately after Plaintiffs left Cigna, Cigna began to force Plaintiffs to jump through unnecessary hoops to get paid for the medically necessary services that they continued to provide to Cigna's members and insureds. For instance, Cigna (through its so-called Special Investigations Unit (or "SIU")) asked for excessive medical records and documentation for each bill prior to payment, supposedly because Plaintiffs were "under investigation." Cigna then proceeded to ignore all records submitted, and to deny virtually all payment on the cryptic basis that "services [were] not rendered as billed."

4. Cigna did not stop there, however. Cigna reached out to Dr. Jadali's patients to falsely accuse Dr. Jadali of committing fraud and to actively encourage his patients to leave Plaintiffs and to find another provider. This is even though there is absolutely no evidence that Dr. Jadali has committed fraud in any way, shape or form.

5. Cigna's outrageous behavior, and its overt malice towards Plaintiffs and their business, rises to the level of tortious injury.

6. At all relevant times, and even today, Cigna continues to authorize Plaintiffs to provide certain medical services to its members and insured. Cigna knowingly gave special authorization for these medically necessary services even though it had no intention whatsoever of paying Plaintiffs.

7. As a result, Plaintiffs have been harmed in the amount of at least $5 million, plus applicable interest, and punitive damages, which encompasses both Cigna's failure to pay for medically necessary treatment and the ongoing harm to Plaintiffs' business.

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GENERAL ALLEGATIONS

8. Plaintiff Dr. Michael Jadali is board certified in Physical Medicine and Rehabilitation by the American Board of Physical Medicine and Rehabilitation.

9. Dr. Michael Jadali is the founder and the chief pain specialist for plaintiff Center for Pain & Rehabilitation Medicine ("CPRM"), a medical clinic located in San Jose, California. CPRM's goal is the treatment of pain and fatigue through extensive medical history, lifestyle assessment, and physical examination to establish personalized proactive treatment plans for each of the patients in its care.

10. Dr. Michael Jadali is also the founder and owner of plaintiff Pacific Coast Medical Clinic, a clinic located in San Jose, California.

11. Together, Plaintiffs are committed to delivering the safest, highest quality medical care to their patients.

12. Plaintiffs are informed and believe that defendant Cigna Life and Health Insurance Company ("Cigna Life"), is a corporation duly organized and existing under the laws of the State of Connecticut and is authorized to transact, and is in fact transacting the business of insurance in California.

13. Plaintiffs are informed and believe that defendant Cigna Healthcare of California, Inc., ("Cigna Healthcare") is a corporation duly organized and existing under the laws of the State of California and is authorized to transact, and is in fact transacting the business of insurance in California.

14. Cigna Life and Cigna Healthcare are collectively referred to herein as "Cigna."

15. Plaintiffs do not know the true names or capacities, whether individual, corporate, associate, or otherwise, of defendants Does 1 through 50, inclusive, and therefore designates those defendants by such fictitious names. Each of the defendants sued herein as a doe is legally responsible in some manner for the events and happenings referred to and proximately caused the injuries suffered by Plaintiffs. Plaintiffs will amend this Complaint to allege the true names and capacities of these Does when such information becomes known to them.

16. Cigna and the Does are collectively referred to herein as "Defendants."

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17. Plaintiffs are informed and believe that at all relevant times Cigna and the Doe defendants were agents of each other, and had actual or ostensible authority to act on each other's behalf. Plaintiffs are informed and believe that at all relevant times, Cigna and the Doe defendants, and in doing the things hereinafter alleged, were acting within the course and scope of such agency.

18. The manner in which the Defendants have conducted themselves when communicating with Plaintiffs has made it difficult if not impossible to determine which of them has authority to speak for Cigna and/or for each other, and whether they are agents of one another, independent contractors of one another, or what other status they have to each other. For example, when they interact with Plaintiffs, Defendants do not identify the specific legal entity (e.g., Cigna Healthcare or Cigna Life) on whose behalf they are acting. Plaintiffs believe that, for all intents and purposes, Cigna Healthcare and Cigna Life are alter egos of each other, and have such a unity of interest and ownership that the individuality, or separateness, of these corporations has ceased, if it ever existed. Plaintiffs are further informed and believe that the facts are such that an adherence to the fiction of the separate existence of these entities would, under the particular circumstances, permit an abuse of the corporate privilege, sanction a fraud, and/or promote injustice. That being said, the complete facts regarding the relationship between the Defendants remain unclear at this time and cannot be resolved except through discovery in this matter.

19. As a specialized medical clinic, CPRM strives to provide real and lasting relief to patients who live with long-term, chronic, and often intractable pain.

20. In modern medicine today, it is all too easy to seek to manage pain by treating its symptoms, such as by prescribing opioids. Plaintiffs, however, seek to utilize the body's full range of capabilities for managing and coping with pain. Dr. Jadali routinely puts in extra effort and time with his patients to create individualized treatment plans that are tailored to each patient's symptoms.

21. Many of Plaintiffs' patients are referred from highly respected medical institutions such as Stanford Health Care, University of San Francisco Medical Center, and the Palo Alto

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Medical Foundation, often after years of unsuccessful treatment. The patients often arrive with severely restricted mobility, on heavy doses of narcotics, and poor prognoses.

22. Plaintiffs' care and treatment very frequently results in dramatic and functional improvement in the patients' well-being and functional capabilities. Plaintiffs utilize a range of effective and medically accepted treatments to lessen pain without reliance upon addictive narcotics. The course of treatment is customized to the individual patient. Plaintiffs' treatments enable their patients to be freed from their reliance on narcotics and to go about their daily lives.

23. After treating patients, Plaintiffs submit bills for its services to Cigna and other payors. In doing so, Plaintiffs comply with all industry and billing standards.

CIGNA'S FAILURE TO PAY PLAINTIFFS FOR SERVICES RENDERED

24. Plaintiffs' singular focus is to provide excellent care and treatment to their patients. In contrast, Cigna's sole focus in this matter has been to save money at the direct expense of Plaintiffs and to the detriment of Cigna's own patient members and insureds.

25. Prior to rendering service to patients, Plaintiffs call the patient's insurance company to verify that they are covered and the terms of their coverage, and, if necessary, to obtain special authorization from the insurance company. Plaintiffs submit bills seeking reimbursement only after verifying coverage, getting any necessary authorization, and the services have been provided. This arrangement is of tremendous benefit to both the patient and Cigna, neither of whom has to pay the entire bill before Plaintiffs render medical care.

26. For the patient bills at issue, Plaintiffs verified that each patient was covered under a Cigna health insurance plan by requiring such patients to present their Cigna-issued insurance card and by telephoning Cigna to verify the patient's insurance, and to verify that Cigna would provide coverage and pay Plaintiffs for the services at issue. Cigna verified its coverage for the patient and the services at issue, provided special authorization where necessary, and confirmed that Cigna would pay for the services.

27. Where required (for instance, for Botox nerve injections) Cigna provided special authorization for a particular service before it was provided. In other cases, Cigna informed Plaintiffs that no special authorization was necessary prior to Plaintiffs performing the service.

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Plaintiffs relied upon Cigna's representation that the procedure was covered, authorized (or that no special authorization was needed), and that Cigna would pay if Plaintiffs rendered the care Cigna's members and insureds.

28. The process used by Plaintiffs to verify coverage and benefits, get authorization, and confirm that Cigna will pay the provider is an industry-standard method for entering into an agreement to pay for out-of-network services. When out-of-network providers like Plaintiffs call a health plan like Cigna to verify benefits, those providers in effect offer to the plan to render services that the plan has agreed to cover for the plan's members. Likewise, when a health plan verifies the coverage and benefits, this is an industry standard method for the health plan to accept the offer from the provider to render those benefits to the health plan. Similarly, when the health plan states that the services are authorized, or that special authorization is not necessary, this represents an industry standard method for the health plan to grant authorization or to confirm that the provider is authorized to render the services without getting a specific authorization.

29. Cigna has routinely participated in these practices with Plaintiffs for many years. Cigna is well aware that these are the industry-standard methods for communicating the offer, acceptance and formation of an agreement to pay the out-of-network provider for healthcare services. Cigna and Plaintiffs continue to utilize these industry-standard processes, just as they have over the course of years for hundreds of medical bills. Cigna's practice of making payments to Plaintiffs and other out-of-network providers following the above-described industry practice and custom reflects Cigna's understanding that Cigna agreed with Plaintiffs to pay for the services at issue. The problem here is that Cigna refused to properly pay for the services at issue after they were rendered.

30. Another reason that the industry standard practice of benefit verification exists is to inform the provider about any relevant limitations or exclusion under the patient's health insurance. If there is a specific limitation on the coverage stated in the Evidence of Coverage (EOC), such as a limitation on whether the services provided would be covered at all, the industry standard is for the health plan to tell the provider the specific limitation at the time coverage and benefits are confirmed. The bills at issue in this lawsuit are ones for which Cigna verified

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benefits, authorized services where special authorization was necessary. However, Cigna either did not pay, or paid less than the proper amount even though it failed to state any specific limitations during the offer-acceptance process that would support Cigna's underpayment or non-payment.

31. In the healthcare industry, when a healthcare provider enters into written contracts with a health plan it typically agrees to accept reimbursement that is discounted from the provider's total billed charges in exchange for the benefits of being a "network provider" (i.e., a provider with a written contract with the plan to be in-network). These benefits typically include, among other things, steering of patients to the provider to increase volume, certainty as to the amount that will be paid as to avoid disputes, specific standards for timely payment, contracted dispute resolution mechanisms, etc.

32. Conversely, when providers, such as Plaintiffs, are not in-network, the out-of-network provider has no obligation to extend a discount off its standard charges, and is entitled to receive payment based on its charges for the services rendered, so long as those charges are reasonable and customary. The health plan is not entitled to any discount off of the provider's billed charges in these circumstances because the health plan is providing nothing to the provider in return for such a discount, nor is the provider required to comply with any payment administration or appeal procedures not required by the law.

33. Absent an agreement by the parties that states otherwise, the standard in the industry is that out-of-network providers like Plaintiffs are entitled to be paid their reasonable and customary charges. Plaintiffs are informed and believe that their charges are reasonable and customary under industry standards and California law, and that Plaintiffs' billed rates satisfy the California legal standards for "reasonable and customary" value. If there is any deviation from this industry standard, it is customary for the health plan to convey this fact to the provider during the initial verification of benefits.

34. In many cases, Cigna simply failed to pay anything to Plaintiffs at all for the valuable medical services rendered to Cigna's members and insureds. In others, Cigna has paid Plaintiffs at a rate that is significantly lower than the billed charges, reasonable and customary

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value, even after accounting for any specified limitations that Cigna stated during the verification/special authorization process.

35. The services provided to the patients at issue were medically necessary, clinically appropriate under the circumstances, and were consistent with generally accepted standards of care and the agreement that Cigna made to pay Plaintiffs.

36. Cigna was aware of Plaintiffs' standard billed charges because Cigna received many bills and appeals reflecting those amounts. With full knowledge of these standard billed charges, Cigna continued to authorize or communicate that no special authorization was necessary for services provided to its members by Plaintiffs.

37. Cigna has not paid (or has underpaid) Plaintiffs' outstanding bills. It has failed to honor the agreements entered into between the parties to pay for those services. Plaintiffs also are informed and believe that Cigna has not paid them in accordance with the timing, specifications or amounts required California law.

38. Under the California Insurance Code, if a claim is denied by Cigna in part or in whole, Cigna is required to issue a notice within 30 days explaining the reasons for denial in detail. Specifically, Insurance Code Section 10123.13(a) requires:

> The notice that a claim is being contested or denied shall identify the portion of the claim that is contested or denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for contesting or denying the claim. If the reason is based solely on facts or solely on law, the insurer is required to provide only the factual or the legal basis for its reason for contesting or denying the claim.

39. If a claim is not decided within 30 days, "interest shall accrue and shall be payable at the rate of 10 percent per annum beginning with the first calendar day after the 30-working day period." Cal. Ins. Code § 10123.13(b).

40. Similarly, Insurance Code Section 10169(b) instructs:

> "[i]f an insurer . . . issues a decision denying . . . health care services, based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the insured, the statement of decision shall clearly specify the provision in the contract that excludes the coverage.

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41. The Knox-Keene Act also requires health plans to pay health care providers on a timely, reasonable and fair basis, and to provide specifics for reasons to contest or deny the claims. For instance, Health and Safety Code section 1371.35 states (emphasis added):

> (a) A 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. However, 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, 45 working days after receipt of the claim by the health care service plan. The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by revenue code, and the specific reasons for the denial. . .

42. By failing to pay timely, or failing to pay at all, Cigna has not only violated these governing rules and regulations; but it has also, in effect, deprived its members and insureds of the out-of-network medical benefits that the patients bargained and paid for when they agreed to obtain healthcare coverage through Cigna.

SPECIFIC PATIENT BILLS AT ISSUE

43. For patient confidentiality reasons, the hundreds of specific patient bills presently at issue are not attached to this Complaint, but will be provided to Cigna directly. Plaintiffs are informed and believe that Cigna is already aware which patient bills are at issue even without this spreadsheet. Plaintiffs are informed and believe that Cigna's improper payment practices also are ongoing, and therefore, they expect to update the list of specific claims at issue at a future date, unless and until Cigna either ceases, or is enjoined from continuing, its improper practices.

44. For now, Plaintiffs provide the following example claims to illustrate the challenges it has faced in seeking direct reimbursement from Cigna:

a. **Patient 1 (Example 1).** Dr. Jadali performed intercostal nerve injection of lidocaine/marcaine for intercostal spasm. Plaintiffs timely submitted a bill with all necessary medical records attached. Cigna denied the claim for purported lack of information. Plaintiffs appealed and provided the entire record of the encounter a second time. Cigna nonetheless denied

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the claim on the basis that "the information provided does not support the medical necessity for a sciatic nerve injection." CPRM never claimed to have performed sciatic nerve injection; the claim was for intercostal nerve injection. CPRM requested further review of the claim, to which Cigna agreed. Yet Cigna never followed up further, and no payment was made.

b. **Patient 1 (Example 2)**. Several weeks later, Dr. Jadali administered injections of lidocaine/marcaine to the bilateral sacroiliac joints, ilio-lumbar ligaments, and sacroiliac ligaments for spasms of the distal thoracic and lumbar paraspinals. Plaintiffs timely submitted a bill with all necessary medical records attached. Cigna denied the claim for purported lack of information. At Cigna's request, Plaintiffs re-sent the records to Cigna SIU. Cigna failed to do anything with the records. Plaintiffs had to re-send the records to Cigna's claims department on June 22, 2015. Cigna's claims department agreed to review the claim further and respond. Cigna still has not responded.

c. **Patient 1 (Example 3)**. Two months thereafter, Dr. Jadali performed intercostal nerve injection of lidocaine/marcaine for intercostal spasm. Plaintiffs timely submitted a bill with all necessary medical records attached. Several months later, Cigna requested that Plaintiffs provide the very same records that had been provided with the initial claim. Plaintiffs re-sent the records to Cigna on September 21, 2015. On November 17, 2015, Cigna "medical director" Daniel Nicoll, M.D., denied the claim due to purported lack of documentation. However, Dr. Nicoll's letter only indicates he reviewed records received on July 28, 2015. His the decision apparently did not take into account the additional records provided on September 21, 2015. When Plaintiffs attempted to inquire with Cigna regarding this issue, Cigna said that the claim was being handled by SIU, and it would take an additional 90 days. Cigna never got back to Plaintiffs.

d. **Patient 2**. Dr. Jadali saw Patient 2 on referral from her primary care physician for chronic pain of the neck, upper back, and upper ribs, and occasional headaches. Dr. Jadali provided comprehensive evaluation and treatment. On May 4, 2015, Plaintiffs timely submitted a bill with all necessary medical records attached. Cigna took over five months to process the claim, and eventually denied the claim for purported lack of information on October 22, 2015. Plaintiffs contacted Cigna's claims department on October 28, 2015, and inquired what

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information Cigna required. Cigna's claims staff confirmed that the medical records actually were received on May 28, 2015. Cigna said the claim would be sent back for review. Cigna issued a second denial on December 22, 2015, this time purportedly based on: (1) evaluation and management level not supported; and (2) osteopathic manipulative treatment not supported by the medical records. Plaintiffs responded by letter on December 28, 2015, explaining why the reasons for the denial were incorrect. Cigna never responded.

45. For the patient bills at issue, Cigna has: (1) in many cases, failed to pay Plaintiffs anything at all for the services they provided to Cigna's members; (2) in some cases, failed to reimburse Plaintiffs for the reasonable and customary value of such services; (3) in every case, failed to provide the specific legal and factual bases on which its payment decisions were based; (4) failed to deny or contest a claim within the time specified by the Insurance Code and/or the Health & Safety Code, as applicable; (5) improperly demanded "reimbursement" for alleged overpayments after the time specified by California Insurance Code section 10133.66(b) and without a clear explanation of the basis upon which the claims were allegedly overpaid; (6) unilaterally offset alleged "overpayments" against the required reimbursement for other, unrelated bills that Cigna knew it was required to pay, and (7) repeatedly demanded that Plaintiffs submit additional documentation before their bills would even be processed – even after Plaintiffs submitted the requested documentation.

46. Last, Cigna continued denying some claims for payment even after Plaintiffs provided information that undercuts the basis of the denial. For instance, Cigna has refused to pay for laboratory testing performed by Plaintiff CPRM even though CPRM has been fully certified as a moderate-complexity lab under the federal Clinical Laboratory Improvement Amendments (CLIA) of 1998. CPRM has informed Cigna that it is fully and appropriately licensed to perform tests. Cigna ignores this and continues to insist that the services provided by the clinic have not been rendered as billed. Cigna's deliberate ignorance underscores that it has already decided not to pay Plaintiffs, no matter what.

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CIGNA'S UNFAIR AND TORTIOUS CONDUCT

47. Not content to injure Plaintiffs and their patients by failing to handle Plaintiffs' claims as required under the law, upon information and belief Cigna has referred some or all of the claims at issue to its internal "special investigations unit" ("SIU"). Upon information and belief, Cigna's SIU has contacted Plaintiffs' patients and, without any factual basis, falsely accused Plaintiffs of fraud. Plaintiffs have personally witnessed at least one instance in which Cigna directly told a patient that "Dr. Jadali was under investigation for fraud," even though Cigna had no basis for making that statement. Cigna's clear and malicious intent in doing so was to deter such patients from receiving care from Plaintiffs in the future.

48. In particular, members of the SIU have gone out of their way, on numerous occasions, to tell Plaintiffs' patients that Dr. Jadali is "committing insurance fraud," and is "under investigation." Cigna has no basis to believe that these things are true. Plaintiffs comply with all applicable industry billing standards when they submit their bills to Cigna. Moreover, Cigna has no basis to keep Dr. Jadali "under investigation" on an indefinite basis. Plaintiffs have been transparent with Cigna, and several years into the supposed "investigation," there cannot possibly be anything more to investigate at this point. Cigna's claim to be 'investigating' Plaintiffs is therefore nothing more than a sham.

49. Cigna has even gone so far as to urge patients to immediately cease receiving any further treatment from Dr. Jadali or his clinics, and to seek care from other providers. This has caused real and serious disruption to Plaintiffs' business, and to the patients' ongoing care and treatment.

50. Cigna has also harmed Plaintiffs by repeatedly insinuating to Plaintiffs' own employees that Plaintiffs are "committing fraud" – unnecessarily alarming the employees, who are most decidedly not engaged in fraudulent activity. Again, Cigna has no basis for such unfounded and inappropriate behavior.

51. At the same time, Cigna has no qualms about blatantly committing fraud against the Plaintiffs themselves. As explained above, Cigna participated in the industry-standard processes of verification and authorization before Plaintiffs provided medical services to Cigna's

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own members and insureds. Yet when Cigna repeatedly confirmed to Plaintiffs that it agreed pay for the care that Plaintiffs intended to provide to the patients, Cigna knew that it had no intention whatsoever of paying Plaintiffs. Cigna already knew and intended to deny all of Plaintiffs' claims on a wholesale basis.

52. Cigna carried out this fraud by relying upon cryptic and/or nonsensical excuses, such as that Plaintiffs' services were not rendered as billed, or pretending not to have all the medical records it needed from Plaintiffs, despite requesting the same medical records over and over again. Through these misleading tactics, Cigna hoped to stall for time and to distract from its true and intent and purpose, which was not to pay Plaintiffs for the medical services that it encouraged Plaintiffs to continue to provide to Cigna members.

53. Plaintiffs seek both compensatory and punitive damages for the harms that they have suffered.

FIRST CAUSE OF ACTION

(*Breach of Implied-In-Fact Contract*)

54. Plaintiffs incorporate each of the above paragraphs as though fully set forth herein.

55. The conduct between Plaintiffs and Cigna created one or more implied-in-fact contracts whereby Plaintiffs agreed to provide medical services to Cigna patients, and Cigna agreed to pay Plaintiffs for such services.

56. During the insurance verification process, Cigna confirmed that the services at issue were covered and that Cigna would pay for the services.

57. Cigna either provided authorization for the medical services in question, or informed Plaintiffs that no authorization was needed before those services were provided.

58. Cigna has paid in the past for the services provided by Plaintiffs, which is further acknowledgement by Cigna of its obligation to reimburse Plaintiffs for the services provided.

59. Cigna has breached and continues to breach the implied-in-fact contracts with Plaintiffs by unilaterally denying and/or reducing payment for medical services provided to Cigna members or insureds, in an amount to be proved at trial. Plaintiffs never agreed to the wrongful

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actions taken by Cigna. They also never agreed to perform free medical services for Cigna's members or insureds.

60. Plaintiffs have performed all of the obligations required of them under their implied-in-fact contracts with Cigna.

61. Plaintiffs have demanded that Cigna pay for the medical services it has provided to Cigna members, and have sent bills to Cigna for processing and payment. They have demanded payment from Cigna on numerous occasions, and have objected to Cigna's unilateral decisions to reduce the amount of payment and/or deny payment to Plaintiffs for the medical treatment provided to Cigna members or insureds.

62. Plaintiffs have been damaged because Cigna has not paid at all, or in full, for the services. Plaintiffs have been damaged in an aggregate amount to be proven at trial, plus interest.

SECOND CAUSE OF ACTION

(*Book Account*)

63. Plaintiffs incorporate each of the above paragraphs as though fully set forth herein.

64. Within the past four years, Cigna became indebted to Plaintiffs on a book account for money due in an amount to be proven at trial.

65. The written documentation maintained and exchanged by the parties, including the verifications and special authorizations routinely issued by Cigna, and Plaintiffs' bills to Cigna for services rendered, and Cigna's payments to Plaintiffs (if any), reflect the precise "debits" and "credits" that run between Plaintiffs and Cigna.

66. An amount of money to be proven at trial, plus interest, remains due and owing from Cigna. Plaintiffs have therefore been damaged and are entitled to compensation therefor.

THIRD CAUSE OF ACTION

(*Unfair Business Practices*)

67. Plaintiffs incorporate each of the above paragraphs as though fully set forth herein.

68. Cigna has utilized unfair business acts and practices that are designed to destroy and subvert Plaintiffs' ability to obtain proper reimbursement for the services that they provide to

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Cigna's members or insureds. These unfair acts and practices are in violation of the Knox-Keene Act or Insurance Code as applicable, the regulations promulgated thereunder, and the Unfair Business Practices Act.

69. The Knox-Keene Act and the Insurance Code require health plans to pay health care providers on a timely, reasonable and fair basis, and not to engage in unfair payment patterns.

70. Cigna has engaged in unfair business practices by, including without limitation:

(a) Failing to timely, properly, and adequately compensate Plaintiffs for non-contracted services by relying upon pretextual allegations of fraud to purposely underpay the amounts owed to Plaintiffs;

(b) Failing to identify the true reasons for underpaying Plaintiffs' claims or denying them in their entirety, in violation of Sections 10123.13(a) and 10169(b) of the Insurance Code, and Health & Safety Code § 1371.35, and instead relying upon pretextual excuses;

(c) Voluntarily and repeatedly authorizing Plaintiffs to provide services to Cigna's members, and encouraging Plaintiffs to provide such services in reliance upon such authorization, yet refusing to pay Plaintiffs' charges after they, in reliance on Cigna's representations, rendered the medical services to Cigna's patients;

(d) Attempting to drive patients away by improperly suggesting that Plaintiffs were "committing fraud" and/or were "under investigation," without any legitimate basis to do so, and with the improper intent of steering patients to other providers who were more profitable for Cigna, or who were friendlier with Cigna; and

(e) Violating Section 2706 of the Patient Protection and Affordable Care Act (PPACA), which prohibits discrimination against a healthcare provider acting within the scope of its license, despite the fact that Plaintiffs were, at all times, acting within the scope of their professional licensure under California law.

71. Throughout the relevant time period, Cigna's true goal was to deny fair payment for any claim to Plaintiffs, while at the same time encouraging Plaintiffs to continue to provide

HOOPER, LUNDY & BOOKMAN, P.C.
1875 CENTURY PARK EAST, SUITE 1600
LOS ANGELES, CALIFORNIA 90067-2517
TEL.: (310) 551-8111 • FAX: (310) 551-8181

valuable medical services to Cigna's members and insureds. For reasons that are known only to Cigna, Cigna sought to harm Plaintiffs' livelihood, and ultimately, to try to drive them out of business, by executing a concerted campaign of economic warfare against them. Cigna's conduct constitutes illegal, fraudulent and unfair business practices under California Business and Professions Code sections 17200, *et seq.*

72. Plaintiffs are informed and believe that Cigna will continue its ongoing unfair business practices unless and until it is enjoined from doing so.

73. Plaintiffs seek an injunction requiring Cigna to cease and desist from using its unfair business practices as outlined herein, including refusing to pay anything for medical procedures that it has specifically authorized Plaintiffs to perform (or for which it has told Plaintiffs that no special authorization is necessary).

74. Plaintiffs have suffered injury in fact and have lost money or property as a result of Cigna's unfair competition. Plaintiffs have a present and vested interest in the amount Cigna owes for services rendered to its members and/or insureds.

75. Plaintiffs are informed and believe that Cigna's unfair business practices also injure the public at large. For instance, by reducing the amount paid to Plaintiffs (or by refusing to pay them at all), Cigna forces Plaintiffs to turn away patients who wish to receive medical services from them. Cigna's refusal to pay the proper amount also frequently exposes patients to larger patient financial liability. More importantly, patients suffer when they are not allowed a free choice of providers, and are intimidated or misled into switching to another provider due to being exposed to false and/or misleading statements made by their insurer (here, Cigna). Cigna's behavior therefore has harmed competition in the market for pain management services as a whole.

76. Plaintiffs seek restitution of an amount to be proven at trial, which includes, but is not limited to (i) the amounts that Cigna was obligated to pay for the services provided, but Cigna retained; (ii) the lost business suffered by Plaintiffs due to Cigna's conduct; and/or (iii) reputational damage to Plaintiffs, plus any statutory penalties and/or attorneys' fees as available.

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77. Plaintiffs' legal remedies are inadequate in that Cigna's unfair, unlawful and fraudulent conduct is ongoing and repeated litigation to correct its ongoing actions is inefficient for the parties and the Court. Therefore, Plaintiffs also seek an injunction prohibiting Cigna's ongoing conduct in delaying payment, reducing payment and/or denying payment to Plaintiffs for medical services provided to Cigna's members and/or insureds.

FOURTH CAUSE OF ACTION

(*Intentional Interference with Contractual Relations*)

78. Plaintiffs incorporate each of the above paragraphs as though fully set forth herein.

79. When patients came to the Plaintiffs for treatment, they signed paperwork agreeing to be fully liable for the bills for the medical services rendered to them. This was part of Plaintiffs' standard practice for doing business, and is standard in the industry.

80. Cigna knew that its members and insureds had entered into agreements with Plaintiffs to pay Plaintiffs for the bills for the medical services rendered to them. However, Cigna intentionally engaged in a number of unfair and wrongful tactics designed to disrupt the performance of Plaintiffs' contracts with the patients.

81. Among other things, Cigna repeatedly contacted its members and/or insureds who were patients of the Plaintiffs with the express intent of disrupting of those relationships. Upon information and belief, in its communications with these patients, Cigna wrongfully and baselessly accused CPRM of fraud without any reasonable legal and/or factual basis in order to deter such patients from continuing to receive medical services from CPRM. These communications were often initiated by personnel from Cigna's SIU. Upon information and belief, in communications with such patients, Cigna's SIU made the following false, outrageous, and/or harmful statements:

(a) That Dr. Michael Jadali was committing "insurance fraud";

(b) That, as a result, Cigna would not pay any amount for medical care provided by Plaintiffs;

(c) That the patients are not legally obligated to pay for the care provided by Plaintiffs;

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(d) The patients must immediately cease receiving any treatment from Plaintiffs, and should find another provider; and

(e) The patients should not pay Dr. Jadali or CPRM any amount for the care provided to them.

82. At the time that Cigna chose to engage in this wrongful behavior, it knew that its improper actions and statements were likely to lead to the disruption of Plaintiffs' physician-patient relationships, and to make the performance of those the patients' agreements to pay significantly more expensive or difficult, if not impossible.

83. Plaintiffs have been harmed and continue to be harmed to the extent that Cigna members and/or insureds who were patients of the Plaintiffs stopped seeking medical services from them as a result of Cigna's conduct set forth above, and to the extent the patients stopped paying the bills for medical services that had been rendered by Plaintiffs as a result of Cigna's conduct.

84. Cigna's failure to properly reimburse Plaintiffs for medical services (as described herein) added insult to injury. As Cigna was well aware, the patients' inability to pay Plaintiffs' bills, which was largely a result of Cigna's improper denials, made them even more likely to stop seeking medical services from Plaintiffs, and even less likely to pay their bills in full, as they had agreed to do.

85. The impact of these wrongful actions was compounded by Cigna's ongoing representations to Plaintiffs, during the industry-standard insurance verification and authorization processes, that Cigna would continue to pay for the medical services that Plaintiffs intended to provide to Cigna patients. Cigna knew at the time that these statements were made to Plaintiffs that Plaintiffs would rely on such statements in continuing to provide medical services to the patients. Cigna had no intention of paying Plaintiffs, however, so these statements by Cigna were false at the time they were made.

86. Cigna persisted in saying one thing to Plaintiffs to encourage them to continue to provide care, yet at the same time continued to intentionally disparage Plaintiffs in communications with Plaintiffs' patients. By doing this, Cigna intended to maximize the harm to

HOOPER, LUNDY & BOOKMAN, P.C.
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Plaintiffs' patient relationships, Plaintiffs' agreements with their patients, and Plaintiffs' overall business.

87. Cigna's conduct, as described above, was a substantial factor in causing Plaintiffs' harm. Thus, by reason of the foregoing, Plaintiffs have been damaged in an amount to be determined according to proof at time of trial.

88. Cigna's despicable conduct as described herein was committed maliciously, fraudulently and oppressively with the wrongful intention of injuring Plaintiffs and with a willful and conscious disregard of Plaintiffs' rights. Cigna subjected Plaintiffs to cruel and unjust hardship through its intentional misrepresentations, deceit, and concealment of material facts. Moreover, such conduct was undertaken with the approval or upon the direction of Cigna's officer(s), director(s), and/or managing agent(s), including by individuals who were responsible for managing Cigna's SIU. Cigna's conduct was intended to deprive Plaintiffs of property or legal rights, to the detriment of Plaintiffs and to the financial benefit of Cigna. Accordingly, Plaintiffs are entitled to recover exemplary and punitive damages under Civil Code § 3294, in an amount according to proof, in order to punish and to make an example of the Cigna, and to deter such conduct in the future.

FIFTH CAUSE OF ACTION

(*Negligent Interference with Contractual Relations*)

89. Plaintiffs incorporate each of the above paragraphs as though fully set forth herein, and in particular the allegations above pertaining to the Fourth Cause of Action for Intentional Interference with Contractual Relations.

90. In the alternative, Plaintiffs are informed and believe that Cigna failed to act with reasonable care when it performed the wrongful acts alleged above in support of the Fourth Cause of Action.

91. Cigna knew or should have known that Plaintiffs' agreements with their patients, wherein the patients agreed to pay the bills for their medical care, would be disrupted, and performance made more expensive, difficult, or utterly impossible, if Cigna failed to act with

HOOPER, LUNDY & BOOKMAN, P.C.
1875 CENTURY PARK EAST, SUITE 1600
LOS ANGELES, CALIFORNIA 90067-2517
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reasonable care. Yet Cigna nonetheless persisted in the despicable course of action described above.

92. By reason of the foregoing, Cigna interfered with Plaintiffs' contracts, and Plaintiffs have been damaged in an amount to be determined according to proof at time of trial.

SIXTH CAUSE OF ACTION

(*Intentional Interference with Prospective Economic Advantage*)

93. Plaintiffs incorporate each of the above paragraphs as though fully set forth herein.

94. Plaintiffs and their patients were in an economic relationship that would have resulted in an economic benefit to Plaintiffs. Specifically, Plaintiffs had ongoing relationships with many patients who were members and/or insureds of Cigna. These patients were routinely referred to CPRM and Dr. Jadali by a number of highly reputable medical institutions in the Bay Area. They regularly sought medical services from Plaintiffs, and agreed both to be liable for reimbursing Plaintiffs for such services, and to assign their health benefits to Plaintiffs as reimbursement for such services.

95. It was reasonably certain that these relationships would have resulted in future economic benefits to Plaintiffs, as Plaintiffs could have and would have provided medical care to these patients, for which they were very likely to be paid.

96. Cigna knew of these physician-patient relationships with its members and/or insureds. Cigna intentionally engaged in a number of unfair and wrongful tactics designed to disrupt Plaintiffs' relationships.

97. Among other things, Cigna repeatedly contacted its members and/or insureds who were patients of the Plaintiffs with the express intent of disrupting of those relationships. Upon information and belief, in its communications with these patients, Cigna wrongfully and baselessly accused CPRM of fraud without any reasonable legal and/or factual basis in order to deter such patients from continuing to receive medical services from CPRM. These communications were often initiated by personnel from Cigna's SIU. Upon information and belief, in communications with such patients, Cigna's SIU made the following false, outrageous, and/or harmful statements:

(a) That Dr. Michael Jadali was committing "insurance fraud";

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(b) That, as a result, Cigna would not pay any amount for medical care provided by Plaintiffs;

(c) That the patients are not legally obligated to pay for the care provided by Plaintiffs;

(d) The patients must immediately cease receiving any treatment from Plaintiffs, and should find another provider; and

(e) The patients should not pay Dr. Jadali or CPRM any amount for the care provided to them.

98. At the time that Cigna chose to engage in this wrongful behavior, it knew (or should have known) that its improper actions and statements were likely to lead to the disruption of Plaintiffs' physician-patient relationships.

99. Plaintiffs have been harmed and continue to be harmed to the extent that Cigna members and/or insureds who were patients of the Plaintiffs stopped seeking medical services from them as a result of Cigna's conduct set forth above.

100. Cigna's failure to properly reimburse Plaintiffs for medical services (as described herein) further increased the risk that Cigna's own members and/or insureds would be burdened with the responsibility to pay for such services themselves. As Cigna was well aware, the patients' inability to pay Plaintiffs' bills, which was largely a result of Cigna's improper denials, made these patients even more likely to stop seeking medical services from Plaintiffs.

101. The impact of these wrongful actions was compounded by Cigna's ongoing representations to Plaintiffs, during the industry-standard insurance verification and authorization processes, that Cigna would continue to pay for the medical services that Plaintiffs intended to provide to Cigna patients. Cigna knew at the time that these statements were made to Plaintiffs that Plaintiffs would rely on such statements in continuing to provide medical services to the patients. Cigna had no intention of paying Plaintiffs, however, so these statements by Cigna were false at the time they were made.

102. Cigna persisted in saying one thing to Plaintiffs to encourage them to continue to provide care, yet at the same time continued to intentionally disparage Plaintiffs in

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communications with Plaintiffs' patients. By doing this, Cigna intended to maximize the harm to Plaintiffs' patient relationships and their business overall.

103. Cigna's conduct as described above was a substantial factor in causing the patients to stop seeking medical services from Plaintiffs. Thus, by reason of the foregoing, Plaintiffs have been damaged in an amount to be determined according to proof at time of trial.

104. Cigna's despicable conduct as described herein was committed maliciously, fraudulently and oppressively with the wrongful intention of injuring Plaintiffs and with a willful and conscious disregard of Plaintiffs' rights. Cigna subjected Plaintiffs to cruel and unjust hardship through its intentional misrepresentations, deceit, and concealment of material facts. Moreover, such conduct was undertaken with the approval or upon the direction of Cigna's officer(s), director(s), and/or managing agent(s), including by individuals who were responsible for managing Cigna's SIU. Cigna's conduct was intended to deprive Plaintiffs of property or legal rights, to the detriment of Plaintiffs and to the financial benefit of Cigna. Accordingly, Plaintiffs are entitled to recover exemplary and punitive damages under Civil Code § 3294, in an amount according to proof, in order to punish and to make an example of the Cigna, and to deter such conduct in the future.

SEVENTH CAUSE OF ACTION

(*Negligent Interference with Prospective Economic Advantage*)

105. Plaintiffs incorporate each of the above paragraphs as though fully set forth herein, and in particular the allegations above pertaining to the Sixth Cause of Action for Intentional Interference with Prospective Economic Advantage.

106. In the alternative, Plaintiffs are informed and believe that Cigna failed to act with reasonable care when it performed the wrongful acts alleged above in support of the Sixth Cause of Action.

107. Cigna knew or should have known that Plaintiffs' relationships with their patients would be disrupted if Cigna failed to act with reasonable care. Yet Cigna nonetheless persisted in the despicable course of action described above.

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1875 CENTURY PARK EAST, SUITE 1600
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108. By reason of the foregoing, Plaintiffs' patient relationships were disrupted, and Plaintiffs have been damaged in an amount to be determined according to proof at time of trial.

WHEREFORE, Plaintiffs prays for judgment against defendants as follows:

1. For damages in an amount to be proved at trial, plus all applicable interest;

2. For restitution in an amount to be proved at trial, plus all applicable interest;

3. For all attorneys' fees and costs incurred in bringing this action, to the extent recoverable by law;

4. For exemplary and punitive damages on the intentional tort claims, to the extent recoverable by law;

5. For injunctive relief; and

6. For such other relief as the Court deems just and appropriate.

DEMAND FOR JURY TRIAL

Plaintiffs hereby demand a trial by jury.

Dated: January 4, 2019

HOOPER, LUNDY & BOOKMAN, P.C.

By: 

ERIC D. CHAN
Attorneys for Center For Pain & Rehabilitation Medicine

HOOPER, LUNDY & BOOKMAN, P.C.
1875 CENTURY PARK EAST, SUITE 1600
LOS ANGELES, CALIFORNIA 90067-2517
TEL: (310) 551-8111 • FAX: (310) 551-8181