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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF ALAMEDA

DISTRICT COUNCIL #16 NORTHERN CALIFORNIA HEALTH AND WELFARE TRUST FUND, individually and on Behalf of All Others Similarly Situated,

Plaintiff,

vs.

SUTTER HEALTH; SUTTER BAY HOSPITALS; MARINHEALTH MEDICAL CENTER; SUTTER COAST HOSPITAL; SUTTER VALLEY HOSPITALS; SUTTER BAY MEDICAL FOUNDATION; SUTTER VALLEY MEDICAL FOUNDATION, and DOES 1-100.

Defendants.

No. RG15753647
CLASS ACTION

AMENDED COMPLAINT FOR FRAUDULENT, UNLAWFUL AND UNFAIR BUSINESS ACTS AND PRACTICES IN VIOLATION OF CAL. BUS. & PROF. CODE §§ 17200, ET SEQ.

ASSIGNED FOR ALL PURPOSES TO:
Judge: Honorable Michael Markman
Dept: 23

Date Filed: January 6, 2015
Trial Date: None Set

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I. NATURE OF THE ACTION

1. This action seeks recovery under California's Unfair Competition Law ("UCL"), Cal. Bus. & Prof. Code §§ 17200, *et seq*., against Sutter Health and its hospital affiliate co-Defendants for their routine practice of submitting and receiving payment from Plaintiff and the Class – self-funded health benefit plans – on fraudulent, unlawful, and unfair bills for supposed "anesthesia services" provided during medical procedures at their facilities, when such services were (a) not provided, (b) separately billed by a third-party anesthesiologist, or (c) reimbursed through other charges on the hospitals' bills. Defendants' illegal conduct centered on anesthesia services supposedly administered to patients in their operating rooms ("ORs").

2. Defendants' fraudulent, unlawful, and unfair business practices resulted in Plaintiff and members of the Class paying more for anesthesia services than they should have. Specifically, on information and belief, between 2001 and 2013, Defendants submitted tens of thousands of fraudulent, unlawful, and unfair bills for anesthesia services that resulted in members of the Class overpaying Defendants for the anesthesia services purportedly rendered. Through this action, Plaintiff and the Class seek to recover these overpayments.

3. In November 2013, the State of California, in conjunction with a *qui tam* relator, Rockville Recovery Associates, Ltd., settled litigation, which alleged that the Defendants engaged in the fraudulent, unlawful, and unfair billing practices at issue in this Complaint ("*Sutter I*"). *Sutter I* sought civil penalties and injunctive relief under the Insurance Frauds Prevention Act, Ins. Code §§ 1871, *et seq*. The settlement does not foreclose Plaintiff's action.

II. JURISDICTION AND VENUE

4. This Court has jurisdiction over all causes of action asserted herein pursuant to the California Constitution, Article VI § 10 because this case is a cause not given by statute to other trial courts. Federal jurisdiction does not exist in this case because there is no federal question and Plaintiff, Class members, and Defendants reside in the State of California. In addition, Defendants' principal place of business is within California.

5. This Court has jurisdiction over Defendants because their principal place of

business is located in California and they are authorized to, and do in fact, conduct business in California and have intentionally availed themselves of the laws and markets of California through the promotion, marketing, distribution, and sale healthcare services in California.

6. Venue is proper in this Court because (a) Defendants, or some of them, can be found, reside, or transact or have transacted business in Alameda County; (b) Defendants performed many of the relevant acts and omissions in Alameda County; and (c) Plaintiff was injured in Alameda County.

III. PARTIES

7. Plaintiff District Council #16 Northern California Health and Welfare Trust Fund ("Plaintiff" or the "Fund") is a health and welfare fund that serves eligible union members of District Council #16 International Union of Painters and Allied Trades, which has its offices at 2705 Constitution Drive, Livermore, California 94551 (the "Union"). The Fund is administered by Associated Third Party Administrators, whose offices are located at 1640 South Loop Road, Alameda, California, 94502. The Fund paid fraudulent, unlawful, and unfair charges for anesthesia services to one or more Defendants throughout the Class Period.

8. Defendant Sutter Health is a California corporation headquartered in Sacramento County, California and owns, controls, and/or operates affiliated hospitals throughout California, including but not limited to each of the facilities identified in the following paragraphs unless otherwise stated.

9. Defendant Sutter Valley Hospitals is a California corporation in the business of providing medical services, with its principal place of business in Sacramento County. Its sole member is Sutter Health. Prior to June 2016, Sutter Valley Hospitals was named Sutter Health Sacramento Sierra Region. In May 2017, Sutter Central Valley Hospitals merged into Sutter Valley Hospitals. Defendant Sutter Valley Hospitals operates various healthcare facilities that have engaged in misconduct described herein, including but not limited to the following:

a. Sutter Amador Hospital, located in Jackson, California.

b. Sutter Auburn Faith Hospital, located in Auburn,

California.

c. Sutter Davis Hospital, located in Davis, California.

d. Sutter Medical Center Sacramento, located in Sacramento, California.

e. Sutter Roseville Medical Center, located in Roseville, California.

f. Sutter Solano Medical Center, located in Vallejo, California.

g. Memorial Medical Center, located in Modesto, California.

h. Memorial Hospital Los Banos, located in Los Banos, California.

i. Sutter Tracy Community Hospital, located in Tracy, California.

10. Defendant Sutter Bay Hospitals is a California corporation in the business of providing medical services, with its principal place of business in Alameda County. Its sole member is Sutter Health. Prior to February 2016, Defendant Sutter Bay Hospitals was named Sutter West Bay Hospitals. In March 2018, Sutter East Bay Hospitals merged into Sutter Bay Hospitals. Sutter Bay Hospitals operates or has operated various healthcare facilities that have engaged in the misconduct described herein, including but not limited to the following:

a. Alta Bates Summit Medical Center, located in Berkeley, California.

b. Alta Bates Summit Medical Center, Herrick Campus, located in Berkeley, California.

c. Alta Bates Medical Center, Summit Campus, located in Oakland, California.

d. Sutter Delta Medical Center, located in Antioch, California.

e. Mills-Peninsula Medical Center, located in Burlingame,

California.

f. Eden Medical Center located in Castro Valley, California.

g. California Pacific Medical Center, California Campus, located in San Francisco, California.

h. California Pacific Medical Center, Davies Campus, located in San Francisco, California.

i. California Pacific Medical Center, Pacific Campus, located in San Francisco, California.

j. California Pacific Medical Center, St. Luke's Campus, formerly located in San Francisco, California.

k. Novato Community Hospital, located in Novato, California.

l. Sutter Lakeside Hospital, located in Lakeport, California.

m. Sutter Santa Rosa Regional Hospital, located in Santa Rosa, California

n. Sutter Maternity & Surgery Center of Santa Cruz, California.

o. Menlo Park Surgical Hospital, located in Menlo Park, California

11. Defendant MarinHealth Medical Center is a California corporation in the business of providing medical services, with its principal place of business in Marin County. Its sole member was Sutter Health up until July 1, 2010. After that date, Marin General Hospital was no longer part of the Sutter system. Prior to 2019, MarinHealth Medical Center was named Marin General Hospital.

12. Defendant Sutter Coast Hospital is a California corporation in the business of providing medical services, with its principal place of business in Crescent City, Del Norte County. Its sole member is Sutter Health.

13. Defendant Sutter Bay Medical Foundation is a California corporation in the business of providing medical services, with its principal place of business in Emeryville, California. It is affiliated with Sutter Health. Defendant Sutter Bay Medical Foundation operates various healthcare facilities that have engaged in misconduct described herein, including but not limited to the following:

a. Surgical Offices, including but not limited to the following:

1. Fremont Center, in Fremont, California.
2. Palo Alto Center, in Palo Alto, California.
3. Mountain View Center, in Mountain View, California.
4. Redwood City Center, in Redwood City, California.
5. Chanticleer Office (2900), located in Santa Cruz, California.
6. Chanticleer Office (2911), located in Santa Cruz, California.
7. Dominican Way Office, located in Santa Cruz, California.
8. Research Park Office, located in Soquel, California.

14. Defendant Sutter Valley Medical Foundation is a California corporation, in the business of providing medical services, with its principal place of business in Modesto, California. It is affiliated with Sutter Heath. Defendant Sutter Valley Medical Foundation operates various healthcare facilities that have engaged in misconduct described herein, including but not limited to the following:

a. Stockton Medical Plaza, located in Stockton, California.

b. Stockton Surgery Center, located in Stockton, California.

c. Briggsmore Specialty Clinic, located in Modesto, California.

15. Defendants Sutter Health, Sutter Bay Hospitals, MarinHealth Medical Center, Sutter Coast Hospital, Sutter Valley Hospitals, Sutter Bay Medical Foundation, and Sutter Valley

Medical Foundation are sometimes hereafter referred to collectively as the "Sutter Defendants".

16. On information and belief, each Defendant was the agent, joint venture and/or employee of each of the remaining Defendants, and in acting as described herein, each Defendant was acting within the scope of said agency, employment and/or joint venture, with the advance knowledge, acquiescence or subsequent ratification of each and every remaining Defendant.

17. The true names and capacities, whether individual, corporate, associate, representative, or otherwise of Defendants named herein as Does One through One Hundred are unknown to Plaintiffs at this time, and they are therefore sued by such fictitious names pursuant to the California Code of Civil Procedure, Section 474.

18. Plaintiffs will amend this Complaint to allege the true names and capacities of Does One through One Hundred when Plaintiffs ascertain their identities. Each of Does One through One Hundred is in some manner legally responsible for the violations of law alleged herein.

19. The term "Defendants" shall include the Doe Defendants.

20. The acts alleged by this Complaint to have been done by each of the Doe Defendants were authorized, ordered or done by duly authorized officers, agents, employees or representatives of such Doe Defendants, while actively engaged in the management, direction or control of such Doe Defendants' business or affairs.

IV. ALLEGATIONS

A. Anesthesia Generally

21. Anesthesia involves the use of medicines to block pain sensations during surgery and other medical procedures.

22. For purposes of this Complaint, there are three types of anesthesia, listed from least to most severe, administered in hospitals: local anesthesia, conscious sedation ("CS"), and general anesthesia.

23. Local anesthesia provides loss of sensation to pain in a limited area of the body.

In general, the local anesthetic is injected into the cutaneous and subcutaneous tissue of the patient. Local anesthesia can be administered by registered nurses ("RNs").

24. CS is a drug-induced depression of consciousness during which the patient is able to respond purposefully to verbal commands and/or tactile stimulation but otherwise should not feel pain. Because the patient can slip into a deep sleep, the patient must be monitored while under CS. The provider monitoring the patient should have no other responsibilities during the procedure and should remain with the patient at all times. CS anesthetics must be administered by a physician, an anesthesiologist, or a Certified Registered Nurse Anesthetists ("CRNA").[1]

25. General anesthesia is the controlled and reversible state of unconsciousness accompanied by the partial or complete loss of reflexes. While under general anesthesia, the patient loses the ability to independently maintain his airway and to purposefully respond to physical stimulation and verbal command. General anesthesia includes a pre-anesthetic examination and evaluation, prescription of the anesthesia required, administration of the anesthetic drugs, and the intra-operative monitoring of the patient's vitals. Thus, general anesthesia necessitates the continuous and actual presence of an anesthesiologist or a CRNA.

26. In a typical hospital, nearly all procedures that take place in the operating room ("OR") require anesthesia of some form.

27. Most hospitals, including Defendants, do not directly employ their own anesthesiologists or CRNAs. Instead, Defendants contract with third parties such as medical corporations or physician groups to provide anesthesiologists when needed. In exchange, the hospital provides the anesthesiologist with the anesthesia agents (i.e., the pharmaceutical drugs) and the facilities for administering the anesthesia.

28. When these third party anesthesiologists are used, they bill the patient's insurer for their time directly. That being the case, hospitals should not also bill for the anesthesiologists' time. To do so would be to double bill for the exact same service.

B. Overview of Defendants' Billing Practices

[1] Dentists and oral surgeons are also qualified to administer CS anesthetics. In addition, specially trained RNs may *assist* in the administration of CS.

29. Hospital claims are reported on claim forms using "revenue codes." The claims are supposed to follow the National Uniform Billing Committee's ("NUBC") guidelines. These guidelines are set forth in a periodically updated manual: the NUBC Official UB-04 Data Specifications Manual (the "Manual").

30. The Manual lists the revenue codes that hospitals use to bill for their services and the use of their facilities. The Manual is comprehensive; it covers every conceivable cost item a hospital may incur for any given procedure.

31. Revenue codes are four digits long, with the first three reflecting a general category and the fourth reflecting the specific item within that category. The general revenue codes relevant to this action are as follows:

a. 025x: "pharmacy," which captures the charges for anesthesia agents (*i.e.*, the pharmaceutical drugs);

b. 036x: "operating room," which captures charges for the OR suite/theater, including equipment, monitors, supplies, and staffing; and

c. 037x: "anesthesia," which captures the minor gap in hospital charges related to anesthesia that are not captured by other revenue codes such as the services of a non-skilled hospital employee (*i.e.*, a technical assistant) to prepare the OR for the anesthesiologist and certain anesthesia inhalation gases not covered by the pharmacy revenue code.[2]

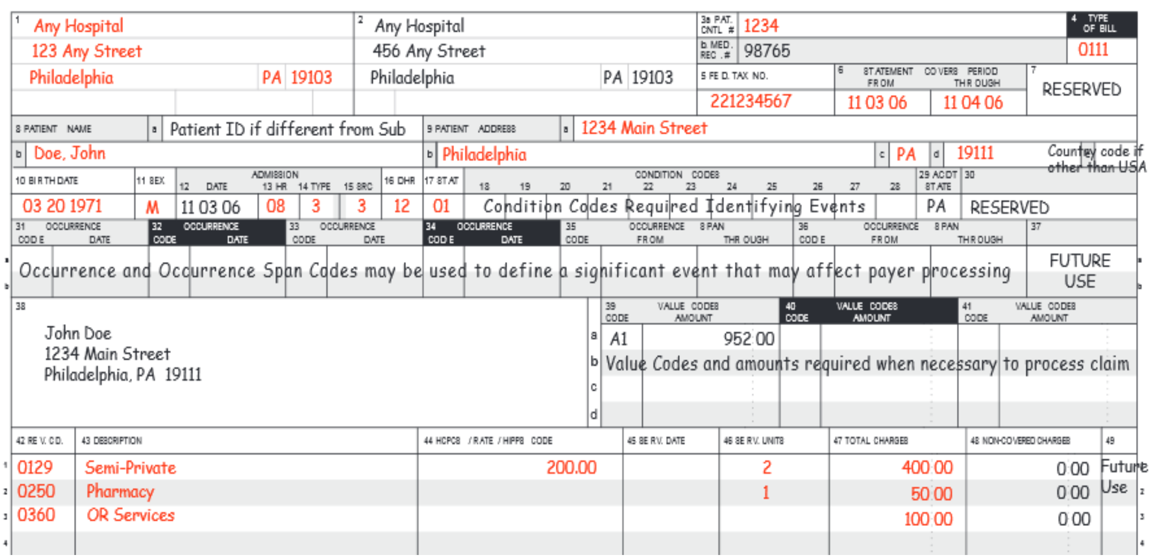
32. Of these, only the 36x revenue code is properly billed on a chronometric (time-

[2] Hospitals may also use the 096x revenue code for "professional services," such as the services of an anesthesiologist or CRNA directly employed by the hospital. However, as noted above, hospitals, including Defendants' hospitals, do not generally employ their own anesthesiologists. This being the case, this revenue code should be rarely, if ever, used; it is exceedingly rare in the industry.

spent) basis; the 25x and 37x revenue codes should be billed on a flat-fee basis.[3] There is no conceivable reason that pharmacy items under the 25x revenue code, which can only be used once, should be billed on a time-spent basis. Similarly, because the 37x only captures ancillary, one-time charges, it is not properly billed on a time-spent basis. In comparison, the OR revenue code, 36x, covers the time spent by OR staff, including doctors, such that billing on a time-spent basis is appropriate.

33. Generally, when billing on a chronometric basis, the hospital bills for the first half hour (or fraction thereof) and fifteen minute increments thereafter.

34. Hospitals, including Defendants' hospitals, maintain a "chargemaster," which is a schedule of every potential charge it could incur in its day-to-day business. Although some end-payors contract with Defendants for discounts off these chargemaster rates, a hospital's chargemaster rates generally apply equally to all patients that access the hospital through private health insurance plans. Each charge code on the chargemaster is assigned one of the NUBC revenue codes described above.


1 Any Hospital
123 Any Street
Philadelphia PA 19103
2 Any Hospital
456 Any Street
Philadelphia PA 19103
3a PAT. CNTL # 1234
b. MED. REC. # 98765
4 TYPE OF BILL 0111
5 FED. TAX NO. 221234567
6 STATEMENT COVERS PERIOD FROM 11 03 06 THROUGH 11 04 06
7 RESERVED
8 PATIENT NAME a Patient ID if different from Sub
b Doe, John
9 PATIENT ADDRESS a 1234 Main Street
b Philadelphia c PA d 19111 Country code if other than USA
10 BIRTHDATE 03 20 1971
11 SEX M
ADMISSION 12 DATE 11 03 06 13 HR 08 14 TYPE 3 15 SRC 3
16 DHR 12
17 STAT 01
CONDITION CODES 18–28 Condition Codes Required Identifying Events
29 ACDT STATE PA
30 RESERVED
31–36 OCCURRENCE / OCCURRENCE SPAN CODE DATE FROM THROUGH: Occurrence and Occurrence Span Codes may be used to define a significant event that may affect payer processing
37 FUTURE USE
38 John Doe
1234 Main Street
Philadelphia, PA 19111
39–41 VALUE CODES CODE AMOUNT
a A1 952 00
b Value Codes and amounts required when necessary to process claim
c
d

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0129	Semi-Private	200.00		2	400 00	0 00	Future Use
0250	Pharmacy			1	50 00	0 00	
0360	OR Services				100 00	0 00	

35. When Defendants (and other hospitals) generate their bills, they aggregate each of the charge codes into the revenue codes described above. So, each revenue code appears on the bill as an individual line item. For instance, if a patient incurred charges that are assigned

[3] Revenue codes are often referenced without the leading zero. Thus, hospital bills may read "250" for "general classification" pharmacy or "258" for "IV solutions."

revenue codes 0129, 0250, and 0360, the bill would include a line for each of those revenue codes and the aggregate amount due under that revenue code; the underlying charges for each of the revenue codes would not be listed. This is demonstrated in the below picture:

36. As a result, Plaintiff and the Class did not (and do not) receive a bill from Defendants that sets forth precisely what services or items were provided for under each revenue code or how those services and items were billed (*i.e.*, on a chronometric/time-spent basis or on a flat-fee basis).

37. Defendants maintain electronic chargemaster files ("CDMs") that include, for each charge code entry, the charge code, charge description, billing description, department, other medical codes, and, most importantly, the revenue code to which that entry is assigned. However, Defendants' publicly-disclosed chargemasters (as opposed to other non-Defendant California hospitals) are far more limited; notably, they exclude the revenue code column, which would permit a payor (or a patient) such as Plaintiff and the Class to identify which charges are assigned to the revenue code that appears on the hospitals' bills.

C. <u>The Payment of Defendants' Bills</u>

38. Plaintiff and the Class are self-funded health benefit plans. Self-funded health benefit plans act as the insurer for their members; they assume the risk of their members' medical expenses and pay medical providers when one of their members receives medical treatment.

39. Self-funded health benefit plans are often administered by third party administrators ("TPAs"). The self-funded health benefit plans pay the TPA a per-member administrative service fee for undertaking various administrative tasks (e.g., preparation of plan documents, member enrollment, record keeping, claim processing, etc.). The self-funded health benefit plans, however, remains responsible for the actual payment of the medical expenses.

40. In exchange for a fee, Preferred Provider Organizations ("PPOs") and Health Maintenance Organizations ("HMOs") provide a network of healthcare providers, including Defendants, to self-funded health benefit plans. Plaintiff contracted with Anthem Blue Cross

Life and Health Insurance Company ("Anthem") for this service and for claims processing services during the class period.

41. Plaintiff and the Class paid Defendants' fraudulent, unlawful, and unfair bills.

42. According to the pleadings in *Sutter I*, the "systemwide agreements" between Defendants on the one hand and PPOs and HMOs on the other hand contain provisions that prevent the HMOs and PPOs from challenging the reasonableness of Defendants' bills. This is accomplished through "hospital audit policies," which expressly provide that questions and opinions regarding "medical necessity," "reasonableness of charges," and "the propriety of a provider's usual and customary practices," are beyond the scope of an audit. Similarly, these contracts impose strict audit time limits and prohibitions on line-item review of bills. Plaintiff is not a party to these "systemwide agreements" and has never seen them. They are considered proprietary or confidential information of Defendants, the HMOs and PPOs.

D. Defendants' Fraudulent, Unlawful, and Unfair Use of the 37x Revenue Code

43. Beginning on or around January 1, 2001 and continuing through at least November 1, 2013, Defendants engaged in the fraudulent, unlawful, and unfair business acts or practices in violation of the UCL described below. On information, between 2001 and 2013, Defendants' submitted tens of thousands of fraudulent, unlawful, and unfair bills for anesthesia services that resulted in members of the Class overpaying Defendants for anesthesia related services. This conduct was established, implemented, and/or ratified at the highest levels of Sutter Health.

1. The "Chargemaster Standardization Project"

44. In November 2000, Sutter Health's Senior Management Team approved a project aimed at standardizing the charge description masters used at Defendants' hospitals. The Senior Management Team retained the services of Arthur Andersen to assist Defendants' clinical department directors and personnel in this project. The project became known as the "chargemaster standardization project."

45. The goal of this project was to develop standardized charging descriptions and

methodologies for the hospital services provided to patients and billed to Plaintiff and the Class.

46. The "chargemaster standardization team . . . decided that standardized time-based level charges for operating room services, time-based level charges for general anesthesia services, and time based charges for monitored anesthesia care and conscious sedation would be appropriate. . . ."

47. These decisions resulted in Defendants implementing the fraudulent, unlawful, and unfair business practice of billing anesthesia under the 37x revenue code on a chronometric basis for the entire time a patient was under general anesthesia.

2. Defendants' Illegal Use of the 37x Revenue Code

48. Because the 37x revenue code is meant to capture only ancillary, one-time charges, the costs billed under this code should generally be less than a few hundred dollars. However, throughout the Class Period, Defendants were billing Plaintiff and the Class as much as $5500 per hour under the 37x revenue code. These 37x charges for "Anesthesia Services" were in addition to the Defendants' chronometric 36x revenue code charges for "Operating Room Service," which reached as high as $13,329 per hour, and the thousands of dollars that were separately charged by the third-party anesthesiologists and CRNAs.

49. Defendants are unable to provide a rational explanation for these charges. Indeed, in sworn statements, Defendants have acknowledged that they are not able to specify the costs that were being recouped by the 37x revenue code.

50. Defendants' misuse of the 37x revenue code took three forms.

51. First, Defendants routinely used the 37x code when there was no legitimate basis for doing so. For instance, and as described above, many procedures require no anesthesia or only (a) CS administered by the attending physician or surgeon or (b) local anesthesia administered via injection. In these instances, there is no reason to use the 37x revenue code, as the charges incurred by Defendants are properly covered by other revenue codes. However, Defendants billed the 37x revenue code in these situations. Similarly, Defendants used the 37x revenue code when no anesthesia was provided, such as where the patient was in a radiology

suite.

52. Second, even where it was appropriate to bill the 37x revenue code, Defendants grossly inflated their bills by improperly billing the 37x revenue code on a time-spent basis rather than on a flat-fee basis. In particular and as described above, after application of the 25x and 36x revenue codes, the only remaining anesthesia-related costs incurred by Defendants are for anesthesia agents not captured by the 25x revenue code, some disposable supplies, and the cost of OR or tray setup by unskilled technicians. Because of the nature of these charges, they should all be billed on a flat-fee basis. However, Defendants systematically billed the 37x revenue code on a chronometric basis for the entire time a patient was in the OR.

53. Defendants' use of chronometric billing for the 37x revenue code constitutes an independent fraudulent, unlawful, and unfair business act or practice. Time-based billing under 37x implies that the patient is being billed for the time spent by an anesthesiologist or other professional, when, in fact, the anesthesiologist bills separately and any time-based services that could result in significant charges by Defendants are captured in other revenue codes, including the 36x revenue code. The only person associated with Defendant's time-based anesthesia charge is the anesthesia technician; however, this technician has limited to no medical training, is not present for medical procedures involving anesthesia, and has no ongoing obligation or responsibilities to the patient during the billed period. At best, the technician is one of several OR personnel who prepare the ORs between patients such that the technician generally has just several minutes of involvement in any given procedure. Nonetheless, Defendants charged the technician as if he was in the OR the entire time. Indeed, Defendants billed the technician simultaneously in multiple ORs and anesthetizing locations at a time, for the entirety of each of these procedures. This resulted in double, triple, or quadruple billing, if not worse. Indeed, there are no other circumstances in which Defendants bill on a time-spent basis when its employees do not have patient care responsibility over the billed period, let alone circumstances in which Defendants billed two time-spent charges simultaneously (here, the OR and anesthesia charges) without providing two distinct services for them throughout the billed period.

54. Third, Defendants charged entities such as Plaintiff and the Class twice for anesthesia gases, under both the 25x and the 37x revenue codes more than ten thousand times during the Class Period. After learning of this double charging, Defendants' key personnel, including CDM Director Cathy Meeter and ethics and compliance officer Kelly Wittmeyer did nothing to advise patients or payors. Indeed, one of Defendants' largest facilities continued to bill for anesthesia gases in this manner through at least September 9, 2013.

55. Defendants' double billing for anesthesia gases using both the 37x and 25x revenue codes constitutes an independent fraudulent, unlawful, and unfair business act or practice.

3. Defendants' 37x Revenues versus Expenditures

56. As a consequence of the foregoing unlawful acts, each Defendant routinely charged, on average, $3000 to $5000 under the 37x revenue code when each was actually entitled to just several hundred dollars under this code, if anything at all. Indeed, Defendants charged as much as $5,500 per hour under the 37x revenue code (in addition to the as much as $13,329 per hour OR charge and the separate bill from the third-party anesthesiologist).

57. The true cost of the anesthesia services provided by the Defendants is set forth below.

Average Cost, Hospital Technical Component of Anesthesia Services (2012)

Sutter Hospital	Average Anesthesia Cost per Surgery[4]
Alta Bates Summit Medical Center (Berkeley)	$ 114
California Pacific Medical Center (San Francisco)	$ 218
Eden Medical Center (Castro Valley)	$ 207
Memorial Medical Center (Modesto)	$ 78
Memorial Hospital (Los Banos)	$ 135

[4] The averages for Alta Bates Summit Medical Center, Memorial Hospital Los Banos, Mills Peninsula, Menlo Park, Santa Cruz Maternity & Surgery Center, Sutter Amador Hospital, Sutter Medical Center Santa Rosa, St Luke's Hospital, and Marin General are estimated based on internal records, rather than anesthesia cost data reported in the Medicare cost reports. San Leandro Hospital is combined with Eden Medical Center for 9 months of 2012.

Menlo Park Surgical Hospital (Menlo Park)	$ 111
Mills-Peninsula Health Services (Burlingame)	$ 187
Novato Community Hospital (Novato)	$ 260
Sutter Amador Hospital (Jackson)	$ 165
Sutter Auburn Faith Hospital (Auburn)	$ 66
Sutter Coast Hospital (Crescent City)	$ 45
Sutter Davis Hospital (Davis)	$ 50
Sutter Delta Medical Center (Antioch)	$ 213
Sutter Lakeside Hospital (Lakeport)	$ 101
Sutter Maternity & Surgery Center of Santa Cruz	$ 148
Sutter Medical Center (Sacramento)	$ 207
Sutter Medical Center of Santa Rosa	$ 186
Sutter Roseville Hospital (Roseville)	$ 102
Sutter Solano Medical Center (Vallejo)	$ 70
Sutter Tracy Community Hospital (Tracy)	$ 68
Marin General Hospital	$ 286

58. As this chart shows, the average cost of the technical component of Defendants' anesthesia services across all of their hospitals was approximately $143.67.

59. Defendants' cost for the "average patient receiving general anesthesia" in the OR ranged from $3.24 to $24.72 for the gas administered.

60. Combining the technical component and the gas costs, Defendants' average cost for their "anesthesia services" was less than $200. Yet, each Defendant was charging thousands of dollars for these anesthesia "services."

61. The resulting overcharges render the purported "discounts" negotiated by PPOs and HMOs for the Plaintiff and the Class illusory. For example, many HMOs and PPOs are able to negotiate discounts ranging from 10% to 35% off Defendants' chargemaster rates. However, by fraudulently, unlawfully, and unfairly inflating their bills through improper use of the 37x revenue code, Defendants submitted claims which were laden with false and inflated charges, notwithstanding any purported "discounting" of the chargemasters.

62. Defendants benefitted from unlawful, unfair, and fraudulent billing practices by receiving money from Plaintiff and the Class that they were not otherwise entitled to receive.

E. <u>Evidence of Defendants' Knowledge of Their Misuse of the 37x Revenue Code</u>

63. At the summary judgment stage in *Sutter I*, the court concluded that the State of

California had offered evidence sufficient to support the reasonable inference that Defendants knew that they were "submitting false, fraudulent, or misleading claims for payment" under the 37x revenue code. This evidence, which is partially described below,[5] affirmatively demonstrates Defendants' knowledge that their use of the 37x revenue code was fraudulent, unlawful, and unfair.

1. The Work Done by Anesthesia Technicians.

64. In depositions, Defendants' employees confirmed that three to four anesthesia technicians were responsible for covering between nine and fifteen anesthetizing locations, that these technicians did not keep track of how much time they spent in any given room, and that these technicians were not in any one room for the entire time the patient was anesthetized. Consistent with these depositions, Defendants' Vice President of Revenue Cycle Management, Mr. Brian Hunter, submitted a declaration that anesthesia technicians do not stay in the room the entire time the patient is anesthetized.

65. More simply, technicians perform simple "room turnover" tasks, such as "wiping down" equipment and restocking between surgical procedures. These tasks take a few minutes to complete. Beyond these duties, technicians are not permitted to be involved in patient care, as the technician position only requires a high school diploma. Yet Defendants bill the 37x revenue code for the entire time the patient is in the OR.

66. Further, a technician covers multiple ORs concurrently, with each OR generating its own time-based anesthesia charge. To bill multiple patients for these technicians for every minute of each patient's OR procedure, even though the technician is not participating in any one of these procedures, is to double, triple, or quadruple bill for the technician's time, or worse.

67. In comparison, Defendants' employees have acknowledged that Defendants do not bill for OR staff who are on standby but not providing a service in the OR. The underlying rationale of these practices – that an employee needs to be working to bill for that employee – further demonstrates defendants' knowledge that its billing practices are fraudulent, unfair, or

[5] Much of the record in *Sutter I* is sealed or redacted such that Plaintiff does not have access to all the evidence available to the State of California in that case.

unlawful.

68. Because these technicians are not present the entire time the patient is anesthetized, yet Defendants charge Plaintiff and the Class for the technicians' time as if the technician were present during the entire OR procedure, Defendants had knowledge that their billing practices for anesthesia technicians were fraudulent, unlawful, and unfair.

2. Billing Practices for Anesthesia in Parallel Situations

69. Defendants' knowledge is also demonstrated by the fact that they do not charge for anesthesia services in two parallel situations – Concious Sedation ("CS") and Labor and Delivery ("L&D") – where no Defendant-employed personnel is monitoring or providing those services.

70. Regarding Defendants' CS billing, although Defendants billed chronometrically for CS, they provided personnel during the entire billed period. Internal documents show that time and again Defendants acknowledged that they should not be adding a time-based 37x charge to patients' bills unless one of their nurses provided an additional anesthesia service to the patient throughout the entire billed period.

71. For instance, Cathy Meeter, Defendants' Chargemaster Director, stated in an email that CS charges applied only "if there is a dedicated staff person that does nothing else but assist the physician in monitoring the patient while sedated." Ms. Meeter also wrote that "[t]he [37x] charge is for the persons, not the monitoring equipment or overhead cost. Those [i.e., the monitoring equipment and overhead] ought to be part of the procedure charge itself. . . ." In yet another email, Ms. Meeter represented that "Hospital billing represents the technical component – labor expenditure by the hospital . . . this code represents that labor expenditure by the hospital . . . if you supply an additional nurse to be the independent, trained observer . . . you should generate a separate charge."

72. The Special Master concluded in *Sutter I*: "This evidence shows that Sutter only charges for CS if there is a Sutter professional present, and infers Sutter's knowledge that anesthesia charges under the 37x code are for persons, not equipment." Defendants willfully

ignored this basic principle for its other anesthesia charges, thereby reaping fraudulent, unlawful, and unfair profits.

73. Regarding Defendants' L&D billing, L&D patients sometimes required anesthesia (e.g., an epidural) and physiological monitoring, just as a patient receiving general anesthesia in the OR would require. Thus, both patients incur time-based charges. However, while patients receiving anesthesia in the OR received 37x charges in addition to the hourly OR charge, Defendants do not impose a 37x charge on L&D patients beyond the L&D hourly charge unless a Defendant-employed CRNA provides the epidural. This is the case even though the same anesthesia equipment might be in use in the L&D room as in the OR.

74. Several of Defendants' high-ranking employees described the rationale for Defendants not imposing a 37x charge on L&D patients. Ms. Meeter wrote that an additional charge was inappropriate because "there is no real expense carrie[d] by the hospital . . . to start and monitor the epidural. Similarly, Ms. Kathy Johnson, Defendants' Director of Billing and Compliance & Revenue Quality, wrote in an email to Ms. Meeter stating that when Defendants' facilities did apply a time-based anesthesia charge to L&D patients even though there was no additional Defendant-employed personnel, "[w]e, in essence, were double charging for the same service."

75. The Special Master in *Sutter I* concluded: "A jury could infer from the evidence by Plaintiff related to CS and L&D, that Sutter knew when it was separately billing for anesthesia in the OR, it was double billing and thereby submitting a false, fraudulent, or misleading bill." The *Sutter I* Court upheld this finding.

3. <u>Billing for the Anesthesia Machine</u>

76. In *Sutter I*, the Defendants argued "that the anesthesia charge under 37x is not only for personnel, but also for 'equipment and supplies that the anesthesiologist uses to deliver anesthesia and monitor the patient.'" However, the Special Master determined at the summary judgment stage that the plaintiff there had offered evidence creating a factual dispute as to whether this equipment was properly billed under the 37x revenue code.

77. For instance, Defendants' internal policies provides that "routine supplies" such as "cost of gowns, drapes, reusable instruments and capital equipment (whether owned or rented) used in the surgery of OR" are "non-billable" and "should be factored into the setting or procedure charge."

78. Defendants' "Policy for Establishment of Charge Codes and Supplies" further elaborates on which supplies are routine (and therefore not billable). This policy states, "Routine supplies are usually used during the customary course of treatment, are included in the unit supplies and are not designated as for a specific patient." And "Routine supply items . . . would generally be available to all patients receiving supplies in that location i.e. emergency room, operating room, cast room, routine nursing area, etc."

79. Ms. Meeter testified that anesthesia is a routine part of surgical procedures in the OR: "If you're in the OR, you're going to have anesthesia. You don't go to the OR without a need for anesthesia." As stated above, Ms. Meeter also wrote that "[t]he [37x] charge is for the persons, not the monitoring equipment or overhead cost. Those [i.e., the monitoring equipment and overhead] ought to be part of the procedure charge itself. . . ."

80. Thus, the anesthesia machine is and always has been a "routine supply" that is not a proper basis to justify a stand-alone 37x charge for the entire period of the anesthesia service and the Defendants' attempt to justify the 37x charge on this basis demonstrates their knowledge that its billing of the 37x charge is fraudulent, unlawful, and unfair.

4. <u>Billing for Anesthesia Gases</u>

81. Further, the billing of anesthesia gases by some of Defendants' hospitals under both the 25x and 37x revenue codes demonstrates that Defendants had knowledge of the illegality of its billing practices.

82. Specifically, Defendants' internal anesthesia policy lists gases that are "included in charge" for the general anesthesia charge under the 37x revenue code but after the chargemaster standardization project, some of Defendants' hospitals charged for these gases under the 25x revenue code. When Defendants finally got around to correcting this double-

billing, they chose not to follow up with Plaintiff and the Class (or patients) to correct the double bills that had already gone out.[6]

83. Even if Defendants "corrected" this practice, the fact that Defendants did not even attempt to notify Plaintiff and the Class of the error – which would have resulted in substantial reimbursement of fees paid to Defendants – demonstrates Defendants knowledge that they were double billing.

5. The Hiding of the 37x Charges.

84. Defendants made a policy decision to obfuscate their charges on their bills. Relying on Defendants' guidelines, Ms. Meeter acknowledged that a charge description should give the patient "some semblance of what it was." However, Defendants' bills offered no meaningful insight into the charges.

85. In particular, the 37x "Anesthesia" line items on patient bills did not describe the underlying charges, and Defendants did not provide information on what charges fell under which revenue codes in their publicly disclosed chargemasters. Other, non-Defendant hospitals in California do not hide the relationship between their revenue codes and the underlying charges in their public chargemasters.

86. That Defendants felt it necessary to hide the basis of the 37x charges further demonstrates their knowledge of the fraudulent, unlawful, and unfair nature of their use of the 37x revenue code.

F. *Sutter I* and its Settlement

87. Defendants' fraudulent, unlawful, and unfair business acts or practices described herein resulted in an insurance fraud lawsuit by the State of California and a subsequent settlement with the State on or around November 1, 2013.[7] The acts complained of herein are substantially the same as the acts complained of in *Sutter I*.

88. Prior to reaching a settlement, Defendants engaged in numerous (and ultimately

[6] Defendants did not dispute this fact in *Sutter I*.

[7] *See State of California v. MultiPlan, et al.*, Case No. 34-2010-00079432 (Sup. Ct., Cnty. of Sacramento).

unsuccessful) tactics at the pleadings stage. In particular, the court in that case denied at least three demurrers, two motions to strike, a motion to compel arbitration, and a motion to strike the State's jury demand.8 The court also dismissed Defendants' cross-complaint against the State.

89. Defendants filed several summary judgment motions in that case, including one concerning the "falsity" requirement of the States' insurance fraud claim. The Special Master recommended that this motion be denied, and the Court agreed, overruling Defendants' objections and denying the summary judgment motion. The Court of Appeals summarily denied Defendants' writ concerning the denial of the motion.

90. Defendants also filed a summary judgment motion in *Sutter I* concerning the specific intent elements of the State's insurance fraud claim. The Court denied Defendants' motion, accepted the Special Master's recommendation, and adopted his findings. In denying Defendants' summary judgment motion on specific intent, the Special Master stated:

> There is no dispute that the Sutter Defendants presented claims to insurers for payment. The court has already found that there is a triable issue of fact regarding whether the claims for payment here were false or fraudulent. . . . If a jury finds that Sutter had knowledge of the falsity or fraudulent nature of the submitted or presented claims, then an intent to defraud will be inferred. As stated by the court in *People v. Scofield*, 17 Cal. App. 3d 1018, 1026 (1971), a person or entity "who willfully submits a claim, knowing it to be false, necessarily does so with intent to defraud.[9]

91. Defendants' counsel in those proceedings admitted the same during a hearing on that motion: "[I]f you know when you submit a claim that it is fraudulent, the inference arises that you did it to try to get money that you would not otherwise have been entitled to get . . . ."[10]

92. As part of the settlement, Defendants agreed to change the way in which they used the 37x revenue code. In relevant part, Defendants agreed to the following terms:

a. For general and complex anesthesia services in the OR, the 37x

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[8] *See* Orders of Jan. 11, 2011; Mar. 11, 2011; Sept. 1, 2011; and Dec. 19, 2011.

[9] Special Master's July 18, 2013 Order on Mot. Of Sutter Defs. For Summ. J. on Specific element of Pls.' Claims at 6:22-7:2.

[10] Desai Decl., Ex. 39 at 13:1-4 (Tr. of June 27, 2013 Proceeding); *see also id.* at 14:1-7.

revenue code is now billed on a two-level flat-fee basis: one charge for anesthesia services through 180 minutes and one charge for anesthesia services greater than 180 minutes.

b. The flat-fee structure described above is "directly related to the specific equipment, supplies, and staff typically provided and available for patients" requiring anesthesia services that are not billed under any other revenue code.

c. The charge descriptions for anesthesia services billed under the 37x revenue code now clearly identify the medical services provided to the patient.

d. The specific UB-04 revenue codes assigned for charges in the Defendants' chargemasters was provided to the State for future publication on the internet.

93. Nothing in the settlement forecloses Plaintiff or the Class's right to seek the remedies requested through this Complaint.

V. Additional Scienter Allegations

94. As described above, through Defendants' sophisticated knowledge of the applicable billing and reporting provisions to insurers and use of contract that limit Plaintiff and the Class's ability to challenge charges, Defendants authored, created, and/or approved fraudulent, unlawful, and unfair medical reports, records, and bills that they submitted to Plaintiff and the Class for payment. Defendants submitted these documents in support of their fraudulent, unlawful, and unfair use of the 37x revenue code.

95. Plaintiff makes the following specific scienter allegations against defendants.

96. **Who:** Defendants, through their employees, officers, and agents, submitted claims for payment to Plaintiff and the Class that contained fraudulent, unlawful, and unfair charges. Inflated bills are submitted directly or indirectly to Plaintiff and the Class for payment by Defendants. Prior allegations in this Complaint detail the role Ms. Meeter played as Director

of Chargemasters and the statements she made about how Defendants should have been using the 37x revenue code, but were not.

97. **What:** The Defendants knew, or were reckless in not knowing, that the charges they submitted under the 37x revenue code were already captured in other revenue codes, including the 25x and 36x revenue codes and in third-party anesthesiologists' separate bills.

98. **When:** Defendants engaged in the fraudulent, unfair, and unlawful practice of submitting 37x revenue codes for services not rendered or services already compensated from roughly January 1, 2001 through at least November 1, 2013. In that time, Defendants have submitted tens of thousands of claims for payment by Plaintiff and the Class that contained fraudulent, unlawful, or unfair 37x revenue code charges as described herein.

99. **Where:** Defendants prepared bills containing fraudulent, unlawful, and unfair 37x revenue code charges in the California counties in which Defendants' hospitals are located and submitted these charges directly or indirectly for payment by Plaintiff and the Class.

100. **How:** Defendants imposed the fraudulent, unfair, and unlawful 37x revenue code charges by billing for "Anesthesia Services" or "Anesthesia" on a time-basis for the entirety of a patient's underlying procedure, which misleadingly implied that the 37x revenue code captured the services of trained professionals or nurses when, in reality, all such charges were already captured by other revenue codes (such as the 25x and 36x revenue codes) and in separate bills from third-party anesthesiologists.

101. **Why:** Defendants engaged in this practice in order to increase revenues per patient and thereby increase their profits.

102. Based on publicly available documents in the *Sutter I* case, Plaintiff believes the following sealed documents will contain additional proof of Defendants' scienter:

a. November 28, 2000 minutes of the meeting of the Sutter Health Senior Management Team ("SMT");

b. January 2001 "FAQs" prepared by Sutter's outside retained consultant, Arthur Anderson, concerning the Charge Master standardization;

c. February 2002 Presentation, Surgery Thought Leadership;

d. Surgery Crosswalk reference (attachment to October 23, 2002 Bieker email);

e. The Desai *Scienter* Declaration, and accompanying exhibits; and

f. Supplemental Desai Declaration, and accompanying exhibits.

VI. TOLLING OF THE STATUTE OF LIMITATIONS

103. Plaintiff lacked actual knowledge of Defendants' fraudulent, unlawful, and unfair billing practices and its injury until after the State of California announced its settlement of *Sutter I* in November 2013, and could not have discovered, through the exercise of reasonable diligence, that Defendants had engaged in fraudulent, unlawful, or unfair billing practices, or that it was injured by them until the settlement of *Sutter I* and its terms were disseminated in the press.

104. The contracts between Defendants and the HMOs and PPOs forbid the questioning of charges. Because the validity of the charges could not be questioned and were purposefully obscured in Defendants' chargemasters and by the billing arrangements that Defendants had with the PPOs and HMOs, Plaintiff and the Class were foreclosed from discovering the injury until Defendants' fraudulent, unlawful, and unfair billing practices filtered down to Plaintiff through public dissemination of the announcement of the settlement in *Sutter I*.

105. Accordingly, the claims of Plaintiff and the Class were tolled up to and through at least November 2013. Plaintiff brings this action within the four year statute of limitations set forth in Cal. Bus. & Prof. Code § 17208.

VII. CLASS ACTION ALLEGATIONS

106. This lawsuit is brought on behalf of Plaintiff individually and on behalf of all those similarly situated pursuant to California Code of Civil Procedure §382. Plaintiff seeks relief on behalf of itself and Class Members defined as follows:

> All self-funded payers that (1) are citizens of California or state and local governmental entities of the State of California and (2) compensated Sutter for any anesthesia services other than conscious sedation administered in operating rooms at its acute care hospitals

at any time from January 1, 2003 to December 31, 2013.

107. On October 15, 2019 Plaintiff filed its motion for class certification. In their opposition, Defendants argued that two of their affirmative defenses concerning arbitration and settlement and release involved individual issues preventing class certification. *See* Defendants' Answer to Complaint, dated December 14, 2018 -- Affirmative Defense Nos. 15 (Arbitration Required), 16 (Release), 22 (Settlement) and 27 (Accord and Satisfaction). The Court heard oral argument on the motion on May 26, 2021. On June 29, 2021, the Court issued its Order Deciding Evidence Motions and Granting Motion for Class Certification. The Court ruled that the class is certified and directed the Plaintiff to meet and confer with Defendants to discuss appropriate procedures to manage the resolution of Sutter's two affirmative defenses. In its order the Court also directed Plaintiff to file "an amendment to the complaint that identifies subclasses that (1) are defined "in terms of objective characteristics and common transactional facts" (*Noel,* 7 Cal.5th 955, 961, 967, 974) and (2) permit Sutter to "fairly and efficiently" present its defenses of release and arbitration (*Duran*, 59 Cal.4th at 29)." Order at 41.

108. After nearly three years of discovery, Sutter has yet to identify a single absent class member who has released any of its claims alleged in this action or agreed to arbitrate them. Its motion to compel arbitration against Plaintiff was denied in an order entered by the Court on April 22, 2016 in part due to the undisputed fact that Sutter's arbitration clause was never shown to Plaintiff and Plaintiff's consent to be bound to it was never obtained, causing the Court to agree with Plaintiff's characterization of the circumstances as a "secret agreement to arbitrate." After full discovery regarding the assertion that Plaintiff could be bound to such an agreement, the Court ruled, "In sum, the court concludes that Sutter has failed to demonstrate the existence of an arbitration agreement that is binding on Plaintiff." This ruling was affirmed by the Court of Appeal in a non-published decision, dated July 9, 2018. Sutter has identified no circumstance that suggests the result would be different for any class member.

109. The Court in its April 22, 2016 ruling did not reach the issue of unconscionability of application of the provisions of the Sutter arbitration clause to non-party class members. For an Insurance Company to make an overpayment claim, according to the

confidential SWAs, it must have made a request for refund within one year of the initial payment of the claim. No discovery rule is permitted to toll this requirement, including any possible claims for inherently secret violations such as fraud or misrepresentation. Moreover, discovery in Sutter's arbitrations is severely limited. The parties are required by the confidential SWAs to exchange spreadsheets identifying each claim in dispute providing the identification of the claim and reason under the contract for the claim of under or overpayment. After the completion of the arbitration, adjusted payments may be made as part of the ordinary claims processing systems of Sutter and the Insurance Companies, without the class members ever knowing that an arbitration process was ever invoked. No class member has ever been advised that the claims asserted in this action have been settled as part of any arbitration or subject to any release.

110. Sutter's arbitration clause is thus unconscionable when applied to a class member seeking to assert a violations of California's unfair competition law against Sutter. The unconscionability is not mitigated in the circumstances of this case by any purported provision of the arbitration agreement that allows the Insurance Company to invoke arbitration on a class member's behalf. In this case, the Insurance Company intermediaries could have been named as defendants for their aid provided to Sutter in repricing the fraudulent claims, as was the case with defendant MultiPlan in the *Rockville* case. This conflict of interest also infects the settlement and release agreements discussed in the next paragraph.

111. Sutter's settlement and release affirmative defense is premised on a series of 22 settlement agreements that it entered with Insurance Companies acting as the claims processing intermediary between class members, including Plaintiff, and medical care providers, including Sutter. The majority of the claims for hospital services at issue in this case are processed by five such intermediaries, Anthem, Blue Shield, Cigna, Aetna and United. Pursuant to Sutter's arbitration clause, these companies agree to arbitrate disputes over the processing of claims in order to ensure proper enforcement of the contractually agreed upon rates for services provided. Periodically, approximately every two or three years, Sutter and each of these Insurance Companies initiate an arbitration proceeding to resolve disputes over the relatively small number

of claims that are alleged to have been improperly processed under the then existing agreement between Sutter and the Insurance Company, called the Systemwide Amendment ("SWA"). These arbitrations are designed to enforce uniform compliance of the SWA for all contractual payments, with Sutter advancing claims that a particular claim was unpaid or underpaid ("underpayments") and the Insurance Company asserting claims for overpayments. These arbitrations are referred to as "claims arbitrations" because they are focused on resolving disputes regarding individual patient bills on a claim-by-claim basis.

112. Sutter has reached 22 settlement agreements (listed in Appendix A) that it contends have released class member claims in this action. These settlement and release agreements were reached between Sutter and the five major Insurance Companies without any participation of a class member, and no class member was aware of the scope of the releases contained in these agreements. They generally resolve claims arbitrations or result from a SWA mandated pre-arbitration meet and confer process. The settlement agreements typically characterize the disputes being settled as "Overpayment Disputes" or "Underpayment Disputes." In such cases, the releases are explicitly limited to those particular disputes. After the filing of this case and a similar class action antitrust case, *UEBT v. Sutter Health, et al.* San Francisco Sup.Ct. No. CGC-14-538451, Sutter took efforts to undermine any ruling by the court that the issues presented in these cases could be decided on a class basis. These efforts include strong-arm monopolistic demands including Sutter's campaign to have class members to sign "Attestations" to bind them to its unconscionable arbitration clause.

113. In a further effort to undermine these class actions, Sutter embarked on a practice of demanding (and receiving) release clauses in its claims arbitration settlement agreements that it contends broaden the releases in those agreements to cover more than the claims disputes raised in the arbitrations and made other changes adverse to putative class members. As part of these revisions, Sutter entered into three settlement agreements with Anthem and United dated in late 2016 or 2017 (identified on Appendix A). These agreements included language stating that that if a self-funded payer successfully argues it is not bound to the releases of overpayment

claims effected by that agreement, then Sutter will no longer be bound to the releases of underpayment claims as to that self-funded payer. One of these agreements with Blue Shield had similar language but that agreement expressly carved the claims asserted in this case from the release. While these releases do not cover any of the claims for unfair competition alleged in this complaint, Sutter has asserted that these provisions create a potential conflict of interest between Plaintiff and other class members. This provision is unenforceable, but even if it were not should Sutter revoke any releases for underpayment as retaliation for a class member's participation in this class action, it would only serve to entitle the applicable class member to the return of the money paid for those medical services, which would be impractical to calculate since the settlement agreements contain only undifferentiated consideration for combined and offsetting overpayment and underpayment claims for both class members and the intermediaries own fully-insured business.

114. For the purposes of litigating Defendants' affirmative defenses of settlement and release and arbitration only, two subclasses are defined as follows:

a. All self-funded payers who contracted with one of the five major intermediaries -- Anthem, Blue Shield, Cigna, Aetna and United -- for claims processing services, where that intermediary entered into an agreement with Sutter that included an arbitration clause ("Arbitration Subclass").

b. All self-funded payers who contracted with one of the five major intermediaries -- Anthem, Blue Shield, Cigna, Aetna and United -- for claims processing services, where that intermediary entered into a settlement and release agreement with Sutter as identified in Appendix A. ("Release Subclass").

115. This lawsuit is properly brought as a class action for the following reasons: (a) the Class is composed of hundreds of geographically dispersed self-funded payers, the joinder of whom in one action is impracticable; (b) the disposition of Plaintiff and Class Members' claims in a class action will provide substantial benefits to the parties and the Court; and (c) the Class is ascertainable and there is a well-defined community of interest in the questions of law or fact

alleged herein, since the rights of Plaintiff and each Class Member were infringed or violated in the same or virtually the same fashion based upon Defendants' uniform misrepresentations and material omissions.

116. The questions of law and fact common to the Class predominate over questions that may affect particular Class Members. Such common questions include the following:

a. Whether Defendants' conduct was and is unlawful, unfair or fraudulent;

b. Whether Defendants' conduct was and is false, misleading or likely to deceive;

c. Whether Defendants were and will continue to be unjustly enriched by virtue of their fraudulent, unlawful and unfair billing practices;

d. Whether Plaintiff and Class Members have been harmed and the proper measure of relief; and

e. Whether Plaintiff and Class Members are entitled to an award of attorneys' fees and expenses against Defendants.

117. Plaintiff DC 16 is a member of the Class, the Arbitration Subclass and the Release Subclass. Plaintiff is a member of the Arbitration Subclass because it contracted with Anthem for claims processing services, where Anthem entered into agreements with Sutter that included an arbitration clause and required Anthem to take steps to assure that its other payers be bound to terms of the agreement, including its dispute resolution and arbitration provisions. Plaintiff is a member of the Release Subclass because Anthem entered into settlement and release agreements with Sutter listed in Appendix A.

118. Plaintiff's claims are typical of the Class and Subclass Members' claims including with respect to all issues raised by Sutter's affirmative defenses. While arbitrability of the putative class member claims have yet to be litigated, the same issues are involved in presenting and opposing the arbitration defense as were litigated in Defendants' unsuccessful motion to compel arbitration as to DC16 claims.

119. Plaintiff will fairly and adequately protect the interests of the Class and Subclasses in that it has no interests antagonistic to or in conflict with the other Class or Subclass Members' interests and Plaintiff has retained attorneys experienced in class actions and complex litigation.

120. With respect to a portion of the Release Subclass potentially impacted by the three agreements with Anthem or United that contain the revocation of Sutter's underpayment release provision, no actual conflict is presented. As alleged above, the provision is unenforceable and it is speculative that such provision should not be permitted to be invoked in a retaliatory manner for a class member's participation in this case.

121. A class action is superior to other available methods for the fair and efficient adjudication of this controversy for at least the following reasons:

122. Given the relatively modest amount of each individual Class Member's claim and the expense of litigating their claims individually, few, if any, Class Members could afford to pay for competent legal counsel to pursue their individual claims or would seek legal redress individually for the wrongs Defendants committed against them; and absent Class Members have no substantial interest in individually controlling the prosecution of individual actions;

123. This action will promote an orderly and expeditious administration and adjudication of the Class claims, economies of time, effort and resources will be fostered and uniformity of decisions will be ensured; and

124. Plaintiff knows of no difficulty that will be encountered in the management of this litigation which would preclude its maintenance as a class action.

125. Plaintiff seeks equitable relief on behalf of the entire Class on grounds generally applicable to the entire Class.

VIII. CLAIMS FOR RELIEF

FIRST CLAIM FOR RELIEF
Fraudulent Business Acts and Practices in Violation of California Business & Professions Code §§ 17200, *et seq.*

126. Plaintiff re-alleges and incorporates herein by reference, as though fully set forth

here, all preceding paragraphs of this Complaint.

127. Plaintiff brings this cause of action individually and on behalf of the Class.

128. California Business and Professions Code §§ 17200, et seq. prohibits acts of unfair competition, which mean and include any "fraudulent . . . business practices."

129. As more fully described above, Defendants' acts and practices with respect to the 37x revenue code have a tendency to deceive, and have deceived, Plaintiff and the Class, thus constituting a fraudulent business act or practice.

130. Defendants presented bills for payment by Plaintiff and the Class that were false and that contained material omissions as to how the charges presented for payment were computed. As the Special Master in *Sutter I* concluded:

> The court has already found that there is a triable issue of fact regarding whether the claims for payment here were false or fraudulent. . . . If a jury finds that Sutter had knowledge of the falsity or fraudulent nature of the submitted or presented claims, then an intent to defraud will be inferred. As stated by the court in *People v. Scofield*, 17 Cal. App. 3d 1018, 1026 (1971), a person or entity "who willfully submits a claim, knowing it to be false, necessarily does so with intent to defraud.

131. As just one example of several provided in earlier sections of this Complaint, Cathy Meeter, Defendants' Chargemaster Director, stated in an email that "[t]he [37x] charge is for the persons, not the monitoring equipment or overhead cost. Those [i.e., the monitoring equipment and overhead] ought to be part of the procedure charge itself. . . ." In yet another email, Ms. Meeter represented that "Hospital billing represents the technical component – labor expenditure by the hospital . . . this code represents that labor expenditure by the hospital . . . if you supply an additional nurse to be the independent, trained observer . . . you should generate a separate charge."

132. Defendants either knew, recklessly disregarded, or should have known that their bills—which contained 37x revenue charges that were un-tethered from the legitimate use of this revenue code—were false, misleading, untrue, deceptive, or likely to deceive or mislead the public, Plaintiff and the Class.

133. Plaintiff and the Class relied upon Defendants' material omissions,

nondisclosures and representations to their detriment.

134. Plaintiff and the Class have suffered injury in fact and have lost money as a result of Defendants' unfair competition and violations of law in that they paid Defendants for services that were never rendered or were grossly inflated; they would not have agreed to pay Defendants had they known that Defendants were mischarging them; and they are therefore entitled to the relief available under Business and Professions Code §§17200, et seq., as detailed herein.

SECOND CLAIM FOR RELIEF
Unlawful Business Acts and Practices in Violation of California Business & Professions Code §§ 17200, *et seq.*

135. Plaintiff re-alleges and incorporates herein by reference, as though fully set forth here, all preceding paragraphs of this Complaint.

136. Plaintiff brings this cause of action individually and on behalf of the Class.

137. California Business and Professions Code §§ 17200, et seq. prohibits acts of unfair competition, which mean and include any "unlawful . . . business practices."

138. As alleged herein, during the Class Period, Defendants uniformly failed to inform Plaintiff and the Class of the true cost of anesthesia services it charges them. Specifically, Defendants submitted bills for anesthesia services using the 37x revenue code that were never administered by Defendants or were grossly inflated.

139. As a result, Defendants' uniform policies, acts, omissions, and practices, among others, violate numerous provisions of California statutory and common law, including, but not limited to the following:

a. California Penal Code § 550, which provides, in relevant part, that "[i]t is unlawful to . . . [k]nowingly prepare, make, or subscribe any writing, with the intent to present or use it, or to allow it to be presented, in support of any false or fraudulent claim" Defendants violated this provision of the Penal Code by omitting material facts, including, but not limited to, an explanation of the services actually

rendered using the 37x revenue code, that fact that technicians were double, triple and quadruple billing for the time they spent in the OR, and that Defendants were billing for gas separately when it was also included in other revenue codes, all as set forth more fully elsewhere in this Complaint; and

b. California Civil Code §§ 1709-10 (Deceit). Section 1709 provides, in relevant part, that "[o]ne who willfully deceives another with intent to induce him to alter his position to his injury or risk, is liable for any damage which he thereby suffers." Section 1710 defines deceit, in part, as "[t]he suggestion, as a fact, of that which is not true, by one who does not believe it to be true" and "[t]he assertion, as a fact, of that which is not true, by one who has no reasonable ground for believing it to be true." Defendants' conduct with respect to billing Plaintiff and the Class for anesthesia service under the 37x revenue code was fraudulent and deceptive, as set forth more fully elsewhere in this Complaint.

140. Plaintiff and the Class relied upon these material omissions and misrepresentations to their detriment.

141. Plaintiff reserves the right to allege other violations of law that constitute unlawful business acts or practices based upon the above-described conduct. Such conduct is ongoing and continues to this date.

142. Plaintiff and the Class have suffered injury in fact and have lost money as a result of Defendants' unfair competition and violations of law in that they paid Defendants for services that were never rendered or were grossly inflated; they would not have agreed to pay Defendants had they known that Defendants were mischarging them; and they are therefore entitled to the relief available under Business and Professions Code §§17200, et seq., as detailed herein.

THIRD CLAIM FOR RELIEF
Unfair Business Acts and Practices in Violation of California Business & Professions Code §§ 17200, *et seq.*

143. Plaintiff re-alleges and incorporates herein by reference, as though fully set forth here, all preceding paragraphs of this Complaint.

144. Plaintiff brings this cause of action individually and on behalf of the Class.

145. California Business and Professions Code §§ 17200, et seq. prohibits acts of unfair competition, which mean and include any "unfair . . . business practices."

146. Defendants' conduct constitutes "unfair" business acts and practices because Defendants' practices have caused and are "likely to cause substantial injury" to Plaintiff and Class Members which injury is not "reasonably avoidable" by Plaintiff and the Class and is "not outweighed" by the practices' benefits to Plaintiff and the Class.

147. Alternatively, Defendants' conduct constitutes "unfair" business acts and practices because Defendants' practices are unfair under the legislatively declared policy of section 1871(h) of the California Insurance Code, which provides:

> The Legislature finds and declares as follows:
>
> * * * * *
>
> Although there are no precise figures, it is believed that fraudulent activities account for billions of dollars annually in added health care costs nationally. Health care fraud causes losses in premium dollars and increases health care costs unnecessarily.

148. As more fully described above, Defendants' concealment of charging Plaintiff and the Class for anesthesia services that were never provided or were grossly inflated and not defining or explaining the amounts charged and for each service provided under the 37x revenue code, constitute unfair business acts or practices within the meaning of Cal. Bus. & Prof. Code §§ 17200, et seq., in that the justification for Defendants' conduct is outweighed by the gravity of the consequences to the general public.

149. Defendants have reasonably available alternatives to further their business interests other than by misleading Plaintiff and the Class about its billing practices under the 37x

revenue code. Indeed, the burden and expense of defining the amounts billed for each service under the 37x revenue code and explaining those charges or disclosing how it calculated the services provided under the 37x revenue code would be infinitesimal in comparison to the negative impact and injury to Plaintiff and the Class.

150. Plaintiff and members of the Class could not have reasonably avoided injury because, as more fully described above, Defendants' scheme is designed to keep Plaintiff and the Class from knowing they were improperly charged an inflated cost for anesthesia services under the 37x revenue code and to keep Plaintiff and the Class from discovering that they will be or were charged grossly inflated anesthesia services or anesthesia services that were never actually provided by Defendants.

151. Defendants' failure to disclose these facts, coupled with their restrictive auditing agreements with PPOs and HMOs made it nearly impossible for Plaintiff and the Class to know how much they actually paid for each anesthesia service captured by the 37x revenue code.

152. Plaintiff and the Class were never in a position to avoid injury, due to Defendants' active concealment of material information, and Plaintiff and the Class became trapped between paying the higher 37x revenue code charges, on the one hand, and continuing their legal obligation to pay for their members' healthcare costs on the other.

153. The practice of not defining the amounts charged for each anesthesia service provided in the 37x revenue code deceives Plaintiff and the Class into paying for services that were never rendered or the value of which was grossly inflated, which is contrary to public policy, immoral, unethical, oppressive, unscrupulous and/or substantially injurious to consumers.

154. Defendants' conduct has violated statutory and common law and the policy and spirit of California's statutory law including, but not limited to, California Insurance Code section 1871(h), and significantly harmed Plaintiff and the Class.

155. Plaintiff and the Class have suffered injury in fact and have lost money as a result of Defendants' unfair competition and violations of law in that they paid Defendants for services that were never rendered or were grossly inflated; they would not have agreed to pay

Defendants had they known that Defendants were mischarging them; and they are therefore entitled to the relief available under Business and Professions Code §§17200, et seq., as detailed herein.

IX. PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays for judgment and relief against Defendants and each of them as follows:

A. That the Court certify and maintain this action as a class action and certify the Class defined above;

B. That the Court declare that Defendants' conduct, as detailed above, violates the law, and permanently enjoin Defendants from engaging in the conduct;

C. That the Court award Plaintiff and the Class the costs to investigate and prosecute this lawsuit, and reasonable attorneys' fees and expenses as authorized by law, including pursuant to California Code of Civil Procedure § 1021.5;

D. That the Court award pre-judgment and post-judgment interest at the legal rate;

E. That the Court award equitable monetary relief, including restitution of all ill-gotten proceeds, and the imposition of a constructive trust upon Defendants, or otherwise restrict Defendants from transferring ill-gotten funds to ensure that Plaintiff and Class Members have an effective remedy;

F. That the Court award restitution sufficient to prevent Defendants from being unjustly enriched at the expense of Plaintiff and the Class and to provide for return of the funds Defendants unjustly obtained from Plaintiff and the Class as alleged herein; and

G. Afford such other and further legal and equitable relief as this Court may deem just and proper.

X. JURY DEMAND

Plaintiff demands a trial by jury on all causes of action so triable.

Respectfully submitted,

HAUSFELD LLP

Dated: October 25, 2024

/s/ *Arthur N. Bailey, Jr.*

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APPENDIX A

Settlement and Release Agreement by Anthem and Sutter (effective April 26, 2011) (SHDC00698238)

Settlement and Release Agreement by Anthem and Sutter (effective January 1, 2012) (SHDC00698243)

Settlement and Release Agreement by Anthem and Sutter (effective September 8, 2014) (SHDC00698252)

Settlement and Release Agreement by Anthem and Sutter (effective October 31, 2014) (SHDC00698455)

Settlement and Release Agreement by Sutter and Anthem (effective November 14, 2016) (SHDC00698491) [includes Sutter revocation of underpayment release provision]

Settlement and Release Agreement by Sutter and Anthem (effective March 9, 2017) (SHDC00698499) [includes Sutter revocation of underpayment release provision]

Settlement and Release Agreement by Aetna and Sutter (countersigned July 14, 2010) (SHDC00698224)

Settlement and Release Agreement by Aetna and Sutter (effective April 5, 2013) (SHDC00698228)

Settlement and Release Agreement by Sutter and Aetna (effective December 31, 2015) (SHDC00698468)

Settlement and Release Agreement by Blue Shield and Sutter (effective January 6, 2012) (BSCA_025327)

Settlement and Release Agreement by Blue Shield and Sutter (effective March 6, 2013) (SHDC00698313)

Settlement and Release Agreement by Blue Shield and Sutter (effective January 30, 2014) (SHDC00698442)

Settlement and Release Agreement by Blue Shield and Sutter (effective April 18, 2014) (SHDC00698448)

Settlement and Release Agreement by Sutter and Blue Shield (effective November 15, 2017) (SHDC00698195)

Settlement and Release Agreement by Sutter and Blue Shield (effective February 15, 2018) (SHDC00698186)

Settlement and Release Agreement by and between Sutter and Cigna (effective July 13, 2015)

(SHDC00698204)

Settlement and Release Agreement by PacifiCare and Sutter (effective November 28, 2005) (SHDC00698383)

Settlement and Release Agreement by PacifiCare and Sutter (effective May 26, 2006) (SHDC00698430)

Settlement and Release Agreement by PacifiCare and Sutter (effective August 10, 2006) (SHDC00698387)

Settlement and Release Agreement by United/PacifiCare and Sutter (effective December 7, 2008) (SHDC00698405)

Settlement and Release Agreement by United/PacifiCare and Sutter (effective June 7, 2010) (SHDC00698219)

Settlement and Release Agreement by Sutter and United (effective November 2, 2016) (SHDC00698485) [includes Sutter revocation of underpayment release provision]