

STATE OF NORTH CAROLINA
COUNTY OF WAKE

IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
_____CVS_____

NORTH CAROLINA MEDICAL SOCIETY,)
)
Plaintiff,)
)
vs.)
)
BLUECROSS BLUESHIELD OF NORTH)
CAROLINA,)
)
Defendant.)
_____)

COMPLAINT
(Jury Trial Demanded)

Plaintiff, North Carolina Medical Society (“NCMS” or “plaintiff”), by its attorneys, brings this action both on its own behalf and on behalf of its members, pursuant to the North Carolina General Statutes § 75-1.1 et seq., and North Carolina General Statutes § 1-538.2, et seq., and other statutory and common law, against BlueCross BlueShield of North Carolina, Inc., (referred to herein as “BCBS-NC” or “defendant”), and alleges the following upon information and belief, except as to paragraphs pertaining to plaintiff’s own actions, which are alleged upon personal knowledge:

INTRODUCTION

1. Plaintiff brings this action both on its own behalf and on behalf of its members to enjoin defendant from engaging in the numerous unfair and deceptive acts and practices identified herein, which are designed to delay, deny, impede and reduce lawful reimbursement to NCMS members who are participating physicians in defendant’s networks and who have rendered medically necessary health care services to members of defendant’s managed care plans. NCMS does not bring this action as an assignee of enrollees’ benefits. Moreover, this action does not otherwise seek benefits or other remedies under the Employment Retirement

Income Security Act of 1974 (“ERISA”), the Federal Employee Health Benefits Act (“FEHBA”) or the Medicare Act of 1965, nor does it arise under or relate to these acts.

2. As a result of the extraordinarily unequal bargaining positions between the NCMS members and defendant, and the physicians’ reliance on BCBS-NC to provide access to significant portions of their patient base, BCBS-NC has been able to force NCMS members to enter into one-sided contracts which infringe upon the doctor-patient relationship and threaten the continuity of care physicians provide to their patients.

3. As discussed in detail below, defendant has employed a variety of means to effect their improper and deceptive scheme, including, but not limited to, one or more of the following practices:

- Defendant systematically denies reimbursement to NCMS members for medically necessary services by, inter alia: (i) routinely and unjustifiably refusing to pay for, or reducing payment for, more than one healthcare service per visit or incident, referred to as “bundling”; (ii) routinely and unjustifiably reducing retroactively the amount of reimbursement remitted to NCMS members, referred to as “downcoding”; and (iii) routinely and unjustifiably denying increased levels of reimbursement for complicated medical cases which require NCMS members to expend extra time and resources on the treatment of the patient referred to as “modifiers”.

- Defendant systematically denies payment to NCMS members for medically necessary claims to achieve internal financial targets without regard for individual patients’ medical needs by, inter alia: (i) improperly employing software programs to automatically downcode procedures and/or deny payment to physicians without appropriate clinical review, oversight or justification; and (ii) improperly applying so-called “medical policies” or

“guidelines” in a manner that BCBS-NC knows is unreasonable for the purpose of denying payment for coverage for medically necessary treatments.

- Defendant fails to provide adequate staffing, staff training, or staff supervision to handle NCMS members’ inquiries. In this regard, BCBS-NC has created and maintains an inefficient administrative system designed to frustrate payment to NCMS members by requiring physicians’ offices to make excessive telephone inquiries to obtain proper reimbursement of claims and to resolve contractual or payment disputes.

- Defendant routinely and unjustifiably fails to make payments to NCMS members within the time period prescribed by applicable provisions of North Carolina State law, and requires redundant and excessive requests for medical records and erects other administrative barriers to delay such payments.

- Defendant fails to provide sufficient explanation for its payment denials and reductions.

- Defendant refuses to provide participating physicians with comprehensive fee schedules with Current Procedure Terminology Codes (“CPT”) (the codes recognized by physicians and insurers for reimbursement purposes), particularly in connection with its Costwise program (defined below in paragraph 14).

- Defendant requires physicians to enter into one-sided physician agreements in order for them to provide medical care to patients who receive healthcare through defendant’s managed care plans.

- Defendant has established a method wherein physicians can telephonically or electronically verify the eligibility of patients for coverage under BCBS-NC plans, but routinely refuses to honor these eligibility verifications and retroactively denies claims or seeks refunds of claims for payment made in reliance on these eligibility verifications.

- Defendant frequently and unreasonably demands refunds or recoupments of “overpayments” of claims previously paid, even when the overpayment was based on BCBS-NC’s errors or other circumstances beyond the physician’s control. For example, these overpayment demands can occur as long as seven (7) years after the previous claim has been paid and services have been rendered. Refund demands are often due to BCBS-NC’s inability or unwillingness to maintain current eligibility files on its enrollees, or due to the existence of other primary insurance by enrollee of which BCBS-NC has or should have knowledge. If physician declines to refund monies to BCBS-NC within 45 days, such “overpayments” are automatically deducted from current claims, leaving NCMS members with little or no recourse.

- Defendant has established a complex, bureaucratic and time-consuming appeals process for physician disputes.

- Defendant engages in a practice wherein it frequently requires physicians to participate in all or none of its product lines, referred to as “all products” requirements. This practice occurs by declining to contract with physicians or terminating physicians who do not wish to participate in all BCBS-NC products. All products practices have been particularly detrimental to physicians with ophthalmology specialties, who are required to offer both their professional services and optical products to all or no BCBS-NC enrollees.

- Defendant improperly denies payment to NCMS members by failing to notify physicians whether service will be covered, or by retrospectively denying coverage for a service after the service has already been rendered. This leaves physicians and patients without advance knowledge as to whether payment will be forthcoming for expensive surgeries and other procedures and services.

- Defendant periodically requires physicians to sign “confidentiality agreements” prior to making payment for disputed claims. If physicians then disclose such payments to other physicians, the BCBS-NC confidentiality agreement expressly provides that they will forfeit such payments.

4. As a result of their improper, unfair and/or deceptive scheme, defendant has deprived NCMS members of millions of dollars of lawful reimbursement for healthcare services provided to defendant’s plan members.

5. Adequate and timely reimbursements to NCMS members are necessary to ensure that physicians are able to maintain their practices and provide continuity of care to patients. The delivery of healthcare services promised by defendant depends on reimbursement adequate to cover the costs of delivering such healthcare. Defendant’s failure to provide reimbursement to NCMS members which is adequate to cover the costs of delivering healthcare services to BCBS-NC’s enrollees has resulted in tremendous hardships for defendant’s participating physicians.

6. As a result of the unfair and deceptive practices, defendant has repeatedly violated the North Carolina General Statutes § 75.1.1, North Carolina General Statutes § 58-3-225 and North Carolina General Statutes §1-538.2, and other statutory and common law, and will continue to do so absent injunctive relief. BCBS-NC’s wrongful conduct causes direct

injuries to NCMS and NCMS members and strikes at the very heart of the mission of the NCMS – which is to ensure that quality medical care is available to the public. By bringing this action, NCMS seeks an order enjoining BCBS-NC from continuing its wrongful practices.

7. Both NCMS members and NCMS in its own capacity have been injured by the egregious acts and practices of defendant set forth in this Complaint. BCBS-NC's wrongful conduct causes direct injury to NCMS members by delaying, denying, impeding and reducing lawful compensation for services NCMS members have provided to BCBS-NC's enrollees.

8. BCBS-NC's wrongful conduct also causes direct injury to NCMS because defendant's practices have frustrated and have continued to frustrate its efforts to achieve its purpose (described more fully below) of ensuring the delivery of quality medical care to the people of the State of North Carolina.

9. As a result of BCBS-NC's unfair and deceptive conduct, NCMS has been required to devote substantial time and resources to dealing with the issues concerning defendant's unfair and deceptive practices. Specifically, NCMS devotes significant time from several of its employees, including representatives of NCMS's Governmental Affairs and Managed Care departments, to deal with the practices at issue herein. NCMS's efforts to counteract BCBS-NC's unfair and deceptive practices include, inter alia, counseling NCMS members on how to counteract the practices at issue, monitoring BCBS-NC's practices, advocating with BCBS-NC on NCMS's member's behalf, and promoting insurance reform, legislation and regulation.

10. Defendant's conduct has adversely impacted, and continues to adversely impact the general public by, among other things: (a) imposing financial hardships on, and in

some cases threatening the continued viability of, the medical practices run by NCMS members; (b) threatening the continuity of care provided to patients by NCMS members, as required by sound medical judgment; (c) requiring NCMS and NCMS members to expend considerable resources seeking reimbursement that could otherwise be available to provide enhanced healthcare services to defendant' plan members; (d) making it more costly and difficult for NCMS and NCMS members to maintain and enhance the availability and quality of care that all patients receive; and (e) increasing the costs of rendering healthcare services in North Carolina as a result of the additional costs incurred.

THE PARTIES

11. Plaintiff North Carolina Medical Society is a North Carolina not-for-profit corporation organized and existing under the laws of North Carolina since 1849, with its headquarters located at 222 North Person Street, Raleigh, North Carolina 27601. NCMS represents over 11,000 members in North Carolina, including licensed physicians, physician assistants, medical interns and residents, medical students and retired physicians.

12. The philosophy and purpose of NCMS is to promote medical science, medical knowledge, and the highest standards of medical care in North Carolina. NCMS strives to enhance access to medical care of high quality to all people in North Carolina and to promote high standards in the practice of medicine in an effort to ensure that quality medical care is available to the public by inter alia, promoting competence in the art of medical practice, making the medical profession more useful to the public in the prevention and care of disease and improving the quality of life. NCMS is the largest physician organization in North Carolina. Founded in 1849, NCMS unifies doctors across North Carolina in all specialties and work settings on issues related to, inter alia: the physician-patient relationship, health and insurance regulation, and patient safety. NCMS devotes significant resources to advocating physician

viewpoints in the public policy arena. Specifically, NCMS and its member physicians take an active role in issues raised by private companies, institutions, administrative agencies and the North Carolina General Assembly and work to assure that the views of the medical community are presented in an organized and effective fashion.

13. Both NCMS members and the NCMS in its own capacity have been injured by the egregious acts and practices of defendant as set forth in this Complaint.

14. Defendant BlueCross BlueShield of North Carolina, Inc. is a North Carolina corporation with its principal place of business located at 1830 U.S. 15-501 North, Chapel Hill, North Carolina. Defendant BlueCross BlueShield of North Carolina Inc., also has regional offices throughout the state and, specifically, in Greenville, Wilmington, Greensboro, Morrisville, Charlotte and Hickory. During the time relevant to this Complaint, BlueCross BlueShield of North Carolina, Inc. together with its subsidiaries and affiliates, provided health maintenance organization (“HMO”), preferred provider organization (“PPO”), indemnity health insurance and administrative services (third party administration services) to BCBS-NC’s enrollees, as well as Blue Card products to enrollees of other states’ Blue Cross plans. BCBS-NC has an exclusive agreement to administer the State of North Carolina Comprehensive Major Medical Plan for in excess of 500,000 state employees, teachers and retirees under its “Costwise” product.

15. Defendant, together with its subsidiaries and affiliates, contract with NCMS members to provide healthcare services to BCBS-NC’s enrollees.

JURISDICTION AND VENUE

16. The claims alleged herein arise under the General Statutes of North Carolina § 75-1.1, et seq., and North Carolina General Statutes §1-538.2, et seq., other statutory and common law.

17. This Court has jurisdiction over BCBS-NC because BCBS-NC does sufficient business in North Carolina, has sufficient minimum contacts with North Carolina, including offices located here, and otherwise intentionally avails itself of the markets in North Carolina by establishing and maintaining physician networks and administering healthcare plans with millions of subscribers in North Carolina, and by promoting, marketing, selling and distributing its healthcare services in this state, so as to render the exercise of jurisdiction by the North Carolina courts permissible under traditional notions of fair play and substantial justice.

18. This Court is a proper venue for this action pursuant to N.C. Gen. Stat. § 1-77, et seq., and N.C. Gen. Stat. § 1-82 because BCBS-NC conducts a substantial amount of its business in Wake County, North Carolina, has numerous participating physicians in this district, and provides healthcare products and services to numerous Wake County residents, including numerous state employees and teachers covered under BCBS-NC products. Moreover, the plaintiff is located in Wake County and Wake County is the chosen forum of the plaintiff.

FACTUAL ALLEGATIONS

Background

19. BCBS-NC is among the largest health insurers in North Carolina and sells a variety of healthcare insurance products. Defendant currently enrolls over 2.9 million persons, representing 32% percent of the private health insurance market in North Carolina. Each healthcare product offered by BCBS-NC in the State of North Carolina allows members to select physicians from a network of participating physicians.

The Terms of the Participating Physicians' Agreements

20. In order to participate in BCBS-NC's network of physicians, each NCMS physician or physician group practice is required to enter into a standardized, one-sided agreement with BCBS-NC ("standard Physician Agreement" or "Physician Agreement").

Although the terms of the standard Physician Agreement are far less favorable to the physicians than to defendant, physicians are compelled to sign the standard Physician Agreement because the physicians need to participate in defendant's health plans to increase and/or maintain their patient volume, and to make high quality and necessary healthcare services available to as many people in the community as possible.

21. The contractual terms pertinent or relevant to this case contained in the standard Physician Agreement are identical or substantially similar. These standard Physician Agreements all provide that NCMS members agree to render "Medically Necessary" healthcare services to defendant's plan members in exchange for reimbursement from BCBS-NC at specified rates.

22. The standard Physician Agreement provides:

You [the physician] agree to deliver Medically Necessary Covered Services to Members as indicated in the attached Addenda, and all obligations and other terms of the Addenda are incorporated by reference into this Master Agreement. The fact that a Practitioner may prescribe, order, or approve a service or supply does not, of itself, make it a Covered Service or Medically Necessary. We expressly reserve the right to require referral of the Member to a more cost effective treatment setting in order for the services to constitute Medically Necessary Covered Services.

The standard Physician Agreement further defines the term "Covered Services" as follows:

"Covered Services" means the benefits and services, goods, equipment and supplies specified in the Benefit Plan to which Members are entitled in accordance with the terms and conditions thereof. We may compare the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be Covered Services.

With respect to compensation, the standard Physician Agreement provides as follows:

We agree to pay you for the Covered Services provided to Members in accordance with the payment provisions set forth in the attached Addenda, and as otherwise set forth in this Agreement.

The payment provision in the Addendum to the standard Physician Agreement provides as follows:

“Fee Schedule” We agree to pay and you agree to accept as payment in full for covered services delivered to Members during the term of the Master Agreement and this Addendum or as otherwise provided herein, the lesser of your usual charge or the amount specified in our fee schedule in effect on the date of service or supply is rendered and incorporated herein by reference as follows: (i) for Members enrolled in preferred provider Benefit Plans covered by this Addendum, our preferred provider fee schedule; and (ii) for Members enrolled in indemnity Benefits Plans covered by this Addendum, our indemnity fee schedule.

These terms can be, and are, utilized by BCBS-NC in an improperly narrow fashion.

BCBS-NC alters its definition of covered services to deny NCMS members payment for services rendered to plan members.

23. Defendant employs “medical resource management” systems (including “medical policies”) to determine, both prospectively and retroactively, whether healthcare services are compensable. Neither the standard Physician Agreement nor BCBS-NC’s medical policies contain an adequate description of guidelines, policies, or procedures for determining whether a healthcare service is compensable. Medical policies are subject and are frequently and unilaterally changed, and do not cover all medical services rendered by participating physicians. Thus, the standards for making determinations are not adequately disclosed and are subject to change from one claim to another.

24. As set forth in detail below, contrary to the terms of the standard Physician Agreement, defendant has refused to pay for all or a portion of the medically necessary healthcare services provided by NCMS members to defendant’s plan members and has delayed or reduced payment for other services. Additionally, defendant has failed to act in good faith, choosing instead to wrongfully exploit the medical resource management process to delay and deny payment, and/or to compromise NCMS members’ ability to receive the reimbursement to which they are entitled.

Defendant's Improper and Unfair Contracting Policies and Practices

25. In order to treat patients who are insured by BCBS-NC, BCBS-NC requires NCMS members to enter into the aforementioned standard Physician Agreements with BCBS-NC.

26. If physicians refuse to sign BCBS-NC's one-sided standard Physician Agreements, BCBS-NC may decide to decline to enter into such agreement or to terminate physician's participation. Those physicians are effectively prevented from seeing and treating patients, including long-time patients and patients under current treatment regimens, who are covered for health care under any of BCBS-NC's insurance plans.

27. Physicians who object to contract provisions contained in BCBS-NC's agreements are faced with an untenable choice. They can either accept the standard Physician Agreements that are unfair to both physicians and patients, or they can choose to no longer treat patients who are insured by BCBS-NC.

Defendant's Wrongful Denial of Reimbursement for Medically Necessary Healthcare Services

28. Despite BCBS-NC's representations that it will reimburse physicians in a complete and timely manner, defendant has used the medical resource management process to wrongfully deny and/or delay payment to participating physicians and have thereby injured both NCMS and NCMS members. Indeed, to avoid making timely and complete payments under its agreements, BCBS-NC designed and has engaged in an improper, unfair and deceptive scheme aimed at NCMS members, that adversely affects NCMS members, the defendant's plan members, and the general public, whereby BCBS-NC delays, impedes, denies, or reduces payment of legitimate claims for reimbursement for medically necessary healthcare services rendered by NCMS members to defendant's plan members. Defendant has employed, and

continue to employ, a variety of means to carry out their improper, unfair and deceptive scheme, as detailed below.

Defendant's Improper Application of CPT Codes

29. The American Medical Association (“AMA”) has developed and annually publishes CPT Codes, a systematic listing of descriptive terms and identifying codes for procedures and services performed by physicians, embodying AMA standards. The CPT Codes provide a numeric system for reporting physicians’ procedures and services by coupling a general identification code with a “modifier” to precisely define the procedure or service. The AMA’s coding guidelines have been adopted by the federal Centers for Medicare and Medicaid Services (“CMS”), formerly known as the Health Care Financing Administration (HCFA), and are also published in CMS’s Documentation Guidelines for Evaluation and Management (“E&M”) Services.

30. CMS publishes in the Federal Register its methodology for using and interpreting CPT Codes, thereby providing physicians with clear and unambiguous language as to what is required for reimbursement of a particular CPT Code. In contrast, BCBS-NC neither fully discloses how it uses and interprets CPT Codes, nor identifies the criteria by which it determines to follow or deviate from a particular CPT Code, thereby providing physicians with no opportunity to determine whether a claim for a particular code will be paid in accordance with the CPT guidelines.

31. A variety of factors impact the complexity or difficulty of a particular medical service and the corresponding CPT Code, including, inter alia, the patient’s medical history, the physician’s examination, the level of medical decision making, the counseling involved, the coordination of the patient’s care, the nature of the presenting problem, and the time required.

32. As set forth in detail below, as part of their unfair and deceptive scheme to delay, deny, impede and reduce lawful reimbursement to NCMS members, defendant routinely and unjustifiably depart from the AMA CPT coding guidelines recognized by physicians and insurers for processing claims for reimbursement. Moreover, defendant fails to disclose to NCMS members how they depart from the CPT coding guidelines, thereby making it difficult for NCMS members to know how defendant calculated NCMS members' compensation.

Defendant's Improper Downcoding of Physician Claims

33. BCBS-NC routinely and unjustifiably reduces payment to participating physicians for healthcare services rendered to BCBS-NC enrollees by engaging in "downcoding." The purpose and result of this automatic and improper "downcoding" is to reduce payments to physicians. Defendant engages in these "downcoding" procedures through the use of software, such as "ClaimCheck" and/or "ClaimReview" that is not based on medical necessity. BCBS-NC automatically downcodes for the sole purpose of arbitrarily and wrongfully reducing payments to physicians.

34. BCBS-NC's downcoding determinations are not available to or reviewable by NCMS or NCMS members. In fact, despite the physicians' claims that BCBS-NC's downcoding has been erroneously performed, BCBS-NC routinely upholds the downcoding, without providing an adequate explanation (as is required to be in compliance with the AMA E&M coding and documentation guidelines).

35. For example, physicians who properly submit claims for reimbursement of services performed are routinely and unjustifiably denied all or a portion of their reimbursement as a result of BCBS-NC's improper downcoding efforts. Physicians who submit such claims are not provided with a sufficient explanation why a particular request for reimbursement is downcoded by BCBS-NC.

Defendant's Improper Bundling of Physician Claims

36. In cases where multiple healthcare services are provided to a patient on the same day or in the same visit, BCBS-NC routinely and unjustifiably refuses to pay for all or part of the healthcare services provided — a practice known as “bundling” as the fees for several distinct services are “bundled” into one combined and reduced payment.

37. For example, physicians may perform multiple unrelated services to patients at a single visit only to have BCBS-NC automatically combine such independently recognizable services into one bundled payment (that is far less than what BCBS-NC is contractually obligated to pay), without regard to the services performed or whether such services are recognized as separately reimbursable procedures.

Defendant's Improper Application of “Black Box Edits”

38. BCBS-NC further engages in what the AMA refers to as “black box edits” - using software, such as “ClaimCheck” and/or “ClaimReview” incorporating secret rules or “edits” that result in claim denials when particular codes or combinations of codes are submitted. NCMS and NCMS members are not adequately informed of BCBS-NC’s secret “black box” edits nor has BCBS-NC attempted to justify the use of such edits.

Defendant's Failure to Recognize Modifiers

39. BCBS-NC routinely and unjustifiably fails to recognize codes submitted for increased levels of reimbursement, or “modifiers,” for complicated medical cases that require NCMS members to expend extra time and resources on the treatment of the patient. Physicians use “modifiers” when billing a service or procedure that is particularly complicated or otherwise out of the ordinary, so that they may be properly compensated when an elevated level of care is required.

40. Under AMA coding guidelines, no additional documentation is required for NCMS members to be paid for these additional or more complex services. However, even when physicians submit documentation as to the necessity for extra services warranting a modifier, BCBS-NC refuses to pay for the extra level of care, or repeatedly requires multiple submissions of medical records or erects other administrative barriers prior to payment.

Defendant's Improper Use of Medical Guidelines

41. Defendant's contracts with the NCMS members require that decisions relating to medical necessity be based on accepted medical treatment standards. Contrary to defendant's contractual undertakings, BCBS-NC does not consistently make medical necessity decisions in accordance with applicable professional standards. Instead, BCBS-NC improperly uses inappropriate and inaccurate models, policies and "guidelines" for these crucial decisions.

42. To make these decisions, BCBS-NC utilizes models, policies and guidelines originally promulgated by Milliman and Robertson ("M&R"), and modified by BCBS-NC, as a means to control healthcare expenses through application of its stringent guidelines. BCBS-NC's primary purpose in relying on such models and guidelines is to reduce medical expenses by minimizing the level of medical care that BCBS-NC must cover, in its ongoing efforts to maximize its bottom line.

43. BCBS-NC guidelines, like M&R's, set forth the level of medical care which BCBS-NC will provide coverage for its subscribers, such as the number of days of hospitalization permitted for a particular condition and when members will be permitted to obtain home health, rehabilitation or similar services.

44. Models, policies and guidelines similar to M&R's, as modified by BCBS-NC, are not uniformly "based on sound scientific research findings, professional literature, clinical experience, appropriate, well-recognized methodologies," and do not "reflect the

standard of care practiced in the medical/hospital community in the clinical practice of medicine,” as is required by The Board of Trustees of the American College of Medical Quality.

45. Instead, models, policies and guidelines like M&R’s, as modified by BCBS-NC, use standards to identify the amount of medical care (including length of hospital stays) required in the “optimal” or “best case” circumstances. Such standards are developed by determining, on an actuarial basis, the 10 percent of patients who had the shortest length of hospitalization for particular treatments and setting this as the standard, rather than attempting to establish appropriate guidelines for the “average” or most common patient. In other words, 90 percent of the patients sampled by M&R’s guidelines needed more hospitalization than what the models and guidelines like M&R’s recommend, and yet similar guidelines are used by actuaries at BCBS-NC as the standard by which to judge all coverage decisions based on medical necessity.

46. Moreover, because models and guidelines similar to M&R’s are based on the experiences of a small minority of patients who respond much more favorably to surgery or other treatment than the average individual, the “optimal” scenarios they describe usually are inappropriate for the average patient. As a result, the models and guidelines like M&R’s for various procedures and illnesses generally call for a hospital discharge in less than half the time spent by the average patient.

47. As a result of BCBS-NC’s adoption and inappropriate use of models, policies and guidelines like M&R’s, NCMS physicians are frequently denied reimbursement for treatment that is in fact medically necessary but has been deemed unnecessary when measured by the unrealistic BCBS-NC guidelines. These determinations are often made retroactively, after treatment has been provided, forcing NCMS members to absorb the cost. Where the

determination is made prior to treatment, NCMS members are forced to expend time and resources appealing decisions.

Defendant's Onerous and One-Sided Appeals Process

48. Many NCMS members lack the resources or necessary expertise to successfully appeal denials of reimbursement. NCMS members have become discouraged and often do not file appeals due to the complexity and bureaucratic nature of the appeals process. In these situations patients are often in dire medical need, and time is crucial. For example, in 2002 and as reported by the North Carolina Department of Insurance, 1587 noncertifications were issued by BCBS-NC. Only 177 of these were appealed, and 38.4% were resolved in the member's favor.

Defendant's Failure to Provide Adequate Staffing

49. BCBS-NC has created and maintained an administrative system that is inefficient and designed to frustrate payment of NCMS members by requiring physicians to make excessive telephone inquiries prior to obtaining pre-certification for approval to provide healthcare services, and in order to seek reimbursement. NCMS members are routinely put on hold for extended periods of time and are routinely required to talk to numerous individuals prior to having their call directed to the proper authority. It is frequently impossible to identify the appropriate individual or talk directly with a peer BCBS-NC Medical Director. Furthermore, failure to comply with any administrative policy or procedure is grounds for denial of payment.

Defendant's Failure To Provide Proper Explanations of Denials

50. In furtherance of their unfair, deceptive and/or misleading practices, defendant fails to provide adequate explanation of why denials are being issued. Explanation of Benefits does not contain proper descriptions that would enable physicians to respond to any purported deficiencies in their claims submission.

Defendant's Failure to Provide Participating Physicians with Sufficient Information

51. Despite the requests by participating physicians to do so, BCBS-NC has refused to provide NCMS members with comprehensive fee schedules to be applied to the codes, particularly in its Costwise program.

Defendant's Failure to Make Timely Payments and Pay Interest

52. Pursuant to N.C. Gen. Stat. § 58-3-225, in effect since July 1, 2001, BCBS-NC is required to pay NCMS members within 30 days of receipt of a bill for healthcare services rendered to defendant's plan members submitted in paper or electronic form. In direct contravention of these requirements, BCBS-NC routinely and unjustifiably fails to make payments within the statutorily-prescribed time period, and circumvents the intent of the statute by requiring extensive submission of medical records or erecting other administrative barriers. Moreover, defendant fails to pay 18% interest for claims that are improperly withheld in violation of N.C. Gen. Stat. § 58-3-225.

The Impact of Defendant's Scheme

53. As a result of BCBS-NC's failure to cooperate with NCMS members by reimbursing them for medically necessary healthcare services rendered to BCBS-NC's enrollees, NCMS members have not received monies to which they are contractually entitled and have been required to expend unreasonable amounts of time and resources in efforts to obtain these monies.

54. In addition to the loss of lawful reimbursement, NCMS members have been required to expend large sums attempting to compel BCBS-NC to pay monies owed.

55. BCBS-NC's unfair and/or deceptive course of conduct and business practices has resulted in great harm to the practices of NCMS members. The inability of NCMS

members to obtain the full reimbursement to which they are lawfully entitled has materially impaired NCMS members' ability to provide continuity of quality of care.

56. BCBS-NC's unfair and/or deceptive course of conduct and business practices have injured NCMS in its own right as NCMS's efforts to achieve its purposes have been, and continue to be, frustrated by defendant's practices, and NCMS has been required to devote significant resources to dealing with issues concerning defendant's unfair practices.

57. BCBS-NC's unfair and/or deceptive course of conduct and business practices have forced NCMS to devote significant resources to handling physician practice inquiries, counseling physicians and otherwise helping to identify and counteract the harm caused by BCBS-NC set forth in this Complaint. Specifically, NCMS devotes significant time from several of its employees, including representatives of NCMS's Governmental Affairs and Managed Care Departments, to deal with the practices at issue herein. NCMS's efforts to counteract BCBS-NC's unfair and deceptive practices include, inter alia, counseling NCMS members on how to counteract the practices at issue, monitoring BCBS-NC's practices, advocating with BCBS-NC on NCMS's member's behalf, and promoting insurance reform legislation and regulation.

FIRST CAUSE OF ACTION

(Violation of the General Statutes of North Carolina §75 – 1.1
Monopolies, Trusts and Consumer Protection)

58. Plaintiff repeats and realleges all preceding paragraphs, as if fully set forth herein.

59. As set forth above, defendant has engaged in unfair and/or deceptive acts and practices that delay, impede, and/or deny lawful claims for reimbursement made by members of NCMS who have entered into contracts with defendant.

60. Defendant's unfair and/or deceptive acts and practices were misleading in material respects. NCMS physicians who are participating physicians in defendant's provider networks rendered medically necessary services to defendant's plan members, reasonably expecting to be fully reimbursed for such services in a timely fashion. As a result of defendant's unfair and/or deceptive acts and practices, NCMS physicians have been denied monies to which they are lawfully entitled for medical services rendered to defendant's plan members. Additionally, as a result of defendant's deceptive acts and/or practices, NCMS has been forced to expend significant resources attempting to assist its members in obtaining the monies to which they are lawfully entitled.

61. Defendant's wrongful conduct also constitutes violation of N.C. Gen. Stat. § 58-3-225, as well as, § 1-538.2 (obtaining services through false pretenses) as alleged *infra* and incorporated herein. Defendant's conduct further amounts to an aggravating circumstance in connection with its breach of its Physicians' Agreements with NCMS members.

62. As a result of defendant's unfair and/or deceptive acts and practices, NCMS and members of NCMS have been injured.

63. By reason of the foregoing, defendant has violated, N.C. Gen. Stat. § 75-1.1, et seq.

SECOND CAUSE OF ACTION

(Violation of North Carolina Prompt Claim Payments Under Health Benefit Plans, N.C. Gen. Stat. § 58-3-225)

64. Plaintiff repeats and realleges all preceding paragraphs, as if fully set forth herein.

65. Since its enactment, defendant has consistently violated time-frames for paying claims set forth in the Prompt Claim Payments Under Health Benefit Plans Law, N.C.

Gen. Stat. § 58-3-225 and circumvented and frustrated the purpose of the statute by erecting unreasonable barriers to payment and failed to pay 18% interest for claims improperly withheld.

66. By reason of the foregoing, defendant has violated the Prompt Claim Payments Under Health Benefit Plans Law, N.C. Gen. Stat. § 58-3-225.

THIRD CAUSE OF ACTION
(Breach of Contract)

67. Plaintiff repeats and realleges all preceding paragraphs, as if fully set forth herein.

68. Defendant was and is a party to various written contracts for provision of medical services by NCMS members to defendant's plan members. Under the terms of these contracts, defendant was and is obligated to pay, in full, for medically appropriate services provided NCMS members to defendant's plan members, within a specified time period and/or provide timely notification of any denials of claims for reimbursement and the reasoning underlying any such denials.

69. Pursuant to the terms of these contracts, NCMS members provided medically necessary services to defendant's plan members and billed defendant for such services in accordance with the terms of the contracts and have otherwise complied with all material terms of the contracts.

70. As described above, defendant has failed and neglected to perform under the contracts by refusing to properly and fully reimburse NCMS members for medical services rendered, by reducing without proper justification such reimbursement of claims as are made, and by delaying and impeding reimbursement of claims and physicians' ability to appeal denials of claims, thereby reaping the time value of the monies NCMS members.

71. By reason of the foregoing, defendant has breached its contracts with NCMS members.

FOURTH CAUSE OF ACTION
(Breach of the Covenant of Good Faith and Fair Dealing)

72. Plaintiff repeats and realleges all preceding paragraphs, as if fully set forth herein.

73. By virtue of the contractual relationship between the defendant and NCMS members, an implied duty of good faith and fair dealing, which defendant has breached by engaging in the numerous acts and practices set forth in this Complaint, which are designed to deny, impede, delay, and reduce lawful reimbursement NCMS members to receive reimbursement for the services provided to defendant's plan members.

74. Defendant has further breached its implied duty of good faith and fair dealing by refusing to provide adequate and/or legitimate explanations for its delay, reduction or denial of payments to physicians and by failing to provide sufficient information and procedures to ensure that physicians' claims for reimbursement are properly considered, both initially and in the appeals process set forth in the contracts.

75. Defendant has further breached its implied duty of good faith and fair dealing by engaging in the unfair and deceptive acts and practices described herein, thereby requiring NCMS members to expend an unreasonable amount of time and resources simply pursuing the payments to which they are contractually and lawfully entitled.

76. By reason of the foregoing, defendant has breached the covenant of good faith and fair dealing owed to NCMS members.

FIFTH CAUSE OF ACTION
(Unjust Enrichment)

77. Plaintiff repeats and realleges all preceding paragraphs, as if fully set forth herein.

78. Defendant has represented to NCMS members that they would be fully paid in a timely manner for the medically necessary services they provided.

79. In reliance on these misrepresentations, NCMS members agreed to and did provide to BCBS-NC medically necessary medical services and submitted proper claims documentation.

80. Defendant has, nonetheless, wrongfully failed to timely and fully pay NCMS members for the services they provided to BCBS-NC plan members.

81. While delaying, reducing and denying payments to NCMS members for the services they have provided to plan members, BCBS-NC has received the benefit of the services provided by NCMS members while wrongfully retaining monies it received that were intended to pay for such services by NCMS members.

82. As a result of the foregoing, defendant has been unjustly enriched.

SIXTH CAUSE OF ACTION
(Civil Action Pursuant to N.C. Gen. Stat. §1-538.2 for
Obtaining Services Under False Pretenses)

83. Plaintiff repeats and realleges all preceding paragraphs, as if fully set forth herein.

84. Defendant has knowingly, systematically and designedly obtained the services of NCMS members through false pretenses through false promises of prompt and full reimbursement to NCMS members for medical services rendered to plan members. Such false

pretenses related to subsisting facts as well as the fulfillment of future acts, and violate N.C. Gen. Stat. §14-100(a) and are actionable pursuant to N.C. Gen. Stat. §1-538.2.

85. Defendant's false pretenses were made with the intent to defraud NCMS members into providing medically reimbursable services to BCBS-NC plan members pursuant to the Physicians' Agreements, services for which defendant knew it had no intent to pay, or for which it had no intent to make a timely or full payment.

86. As a result of the foregoing, defendant has violated N.C. Gen. Stat. §1-538.2.

SEVENTH CAUSE OF ACTION

(Breach of Contract Accompanied by Tortious and Fraudulent Acts)

87. Plaintiff repeats and realleges all preceding paragraphs, as if fully set forth herein.

88. Defendant was and is a party to various written contracts for the provision of medical services by NCMS members to BCBS-NC plan members. Under the terms of those contracts, defendant was and is obligated to pay for medically appropriate services provided to enrollees by NCMS members, in full, within a specified time period and/or to provide timely notification of any denials of claims for reimbursement and the reasoning underlying any such denials.

89. Pursuant to the terms of these contracts, NCMS members provided medically necessary services to BCBS-NC plan members and billed defendant for such services in accordance with the terms of the contracts.

90. NCMS members have complied with all material terms of the contracts.

91. As described above, BCBS-NC has intentionally failed and neglected to perform under the contracts by refusing to properly and fully reimburse NCMS members for

medical services rendered and have thereby breached the contracts, which breach was accompanied by fraudulent intent or act, and other tortious acts, based upon the numerous undisclosed fraudulent and unfair acts and practices described herein.

92. Defendant's conduct, as alleged herein, constitutes breach of contract accompanied by fraudulent and other willful and wanton tortious acts.

93. By reason of the foregoing, NCMS members have been injured by defendant's tortious and fraudulent acts.

EIGHTH CAUSE OF ACTION
(For Injunctive and Declaratory Relief)

94. Plaintiff repeats and realleges all preceding paragraphs, as if fully set forth herein.

95. As set forth above, members of NCMS have entered into contracts with defendant pursuant to which defendant affirmatively represented that they would reimburse members of NCMS for medically appropriate services provided to defendant's plan members in a timely manner. Through the conduct described herein, defendant routinely and unjustifiably denies, impedes and/or delays lawful reimbursement to members of NCMS.

96. BCBS-NC's practices described herein are in breach of defendant's contractual obligations with NCMS members and are against public policy and defendant should be prohibited from engaging in these practices in the future.

97. Accordingly, plaintiff, on its own behalf and on behalf of its members who have entered into contracts with defendant, seeks: (i) a declaratory judgment that the above-referenced reimbursement practices are in breach of the contracts between the members of NCMS and defendant and are against public policy; and (ii) injunctive relief prohibiting defendant from engaging in these practices in the future.

98. NCMS and NCMS members will suffer irreparable harm if defendant is permitted to continue to engage in the improper and unlawful practices described in detail above.

99. By reason of the foregoing, NCMS and NCMS members are entitled to declaratory and injunctive relief.

PRAYER FOR RELIEF

WHEREFORE, plaintiff demands that, this Court enter judgment against defendant as follows:

- a. Declaring that defendant's practices, as described herein, constitute unfair and/or deceptive acts and practices that are unlawful under N.C. Gen. Stat. § 75-1.1, et seq.;
- b. Declaring that defendant's practices as described herein violate N.C. Gen. Stat. § 58-3-225;
- c. Declaring that defendant's practices as described herein violate N.C. Gen. Stat. § 1-538.2;
- d. Declaring that defendant has breached the terms of its contracts with NCMS members, as described herein;
- e. Declaring that defendant breached its covenant of good faith and fair dealing with NCMS members, as described herein;
- f. Declaring that defendant breached the terms of its contracts with NCMS members accompanied by tortuous and fraudulent acts, as described herein;
- g. Awarding plaintiff permanent injunctive relief prohibiting, restraining, and enjoining defendant from engaging in the conduct complained of herein, including, inter alia:
 - (i) continuing to direct their internal agents to reduce or fully deny reimbursement without regard to the validity or medical necessity of the services provided;

- (ii) continuing to employ so-called “medical policies” or “guidelines” in an improper manner to deny claims for reimbursement;
- (iii) continuing to bundle claims for separate procedures thereby denying NCMS members all or part of the payment due for some procedures;
- (iv) denying payment of modifiers for complicated medical cases that involve extra time and resources;
- (v) continuing to downcode procedures performed by NCMS members;
- (vi) continuing to use software that automatically downcodes healthcare services provided by NCMS members;
- (vii) failing to pay physicians for lack of an authorization when an authorization was submitted;
- (viii) continuing to violate provisions of North Carolina statutory law regarding payment;
- (ix) forcing physicians and their staff to expend unreasonable amounts of time and resources attempting to obtain the reimbursement to which they are entitled;
- (x) failing to provide adequate explanations for the denial of claims for reimbursement;
- (xi) failing to ensure that procedures exist so that physicians’ claims for reimbursement are appropriately and adequately considered in a timely manner, both initially and in the appeals process;
- (xii) exploiting the parties’ unequal bargaining power in order to force physicians to enter into one-sided contracts on a take-it-or-leave-it basis;

- (xiii) failing to provide for adequate staffing, staff training or supervision to handle NCMS physician inquiries;
- (xiv) refusing to provide participating physicians with comprehensive fee schedules to be applied to CPT codes recognized by physicians and insurers for reimbursement;
- (xv) continuing arbitrary medical policies for denying payments for specific types of medically necessary treatments;
- (xvi) failing to establish adequate eligibility verification processes and to honor its own electronic or telephonic eligibility verifications;
- (xvii) making unreasonable refund demands on previous claims and recouping monies from current claims if physician fails to agree;
- (xviii) engaging in “all products” practices that limit physicians’ ability to make reasonable decisions regard the best interests of the practice and patients;
- (xix) refusing to provide advance predeterminations of benefits such that patients and physicians can reasonably ascertain whether payment will be forthcoming for services rendered by NCMS members;
- (xx) maintaining a complex, bureaucratic and time-consuming appeals process for physician disputes which has the direct effect of discouraging NCMS members from pursuing legitimate appeals;
- (xxi) requiring physicians to execute coercive confidentiality agreement prior settlement of claims disputes;
- (xxii) otherwise interfering with or obstructing the right to full and timely reimbursement to NCMS members;

h. Awarding plaintiff its costs and disbursements incurred in connection with this action, including reasonable attorneys' fees, expert witness fees and other costs; and

i. Granting such other and further relief as the Court deems just and proper.

Dated: January 5, 2004

Respectfully submitted,

By: _____
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