UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

PUGET SOUND SURGICAL CENTER P.S. Plaintiff, v. AETNA LIFE INSURANCE COMPANY, AETNA, INC., AMTRAK HEALTH CARE PLAN, ANCHORAGE SCHOOL DISTRICT ACTIVE EMPLOYEE OPEN CHOICE PPO MEDICAL PLAN, BECHTEL JACOBS COMPANY LLC HEALTH AND WELFARE PLAN, STATE OF ALASKA ALASKACARE EMPLOYEE HEALTH PLAN, BANK OF AMERICA HEALTH CARE PLAN, NORDSTROM, INC. CLASSIC PLAN, STARBUCKS HEALTH CARE PLAN, COSTCO WHOLESALE HEALTH PLAN, SOUND HEALTH AND WELLNESS TRUST PLAN, WESTCO HEALTH PLAN PLAN, LOCKHEED MARTIN CORPORATION TOTAL HEALTH PLAN, and ADOBE SYSTEMS, INC. GROUP WELFARE PLAN Defendants.	)	Civ. No.

By way of this Complaint, and to the best of its knowledge, information and belief, formed upon a reasonable inquiry under the circumstances, Plaintiff Puget Sound Surgical Center ("PSSC") brings this action against Defendant Aetna Life Insurance Company and Aetna, Inc. ("Aetna"), and Defendants National Railroad Passenger Corporation Health Care Plan ("Amtrak Health Care Plan"), Anchorage School District Active Employee Open Choice PPO Medical Plan ("Anchorage"), Bechtel Jacobs Company LLC Health and Welfare Benefit Plan ("Bechtel"), State

of Alaska AlaskaCare Employee Health Plan ("Alaska"), Bank of America Health Care Plan ("BoA"), Nordstrom, Inc. Classic Plan, Starbucks Health Care Plan ("Nordstrom"), Costco Wholesale Health Plan (Costco"), Sound Health and Wellness Trust Plan ("Sound Health"), WESTCO Health Plan ("Westco"), Lockheed Martin Corporation Total Health Plan ("Lockheed"), and Adobe Systems, Inc. Group Welfare Plan ("Adobe") (collectively, the "Plan Defendants"). The Plan Defendants sponsor the Group Benefits Programs under which the PSSC patients described below receive health care coverage, and are upon information and belief self-funded groups (meaning they pay the costs of health care for their employees out of their own assets). The Corporate Benefits Committee of each Plan (or in the case of the State of Alaska AlaskaCare Employee Health Plan, the Commissioner, is the Plan Administrator. Aetna is the claims administrator and third-party administrator ("TPA") for these health care plans. For some PSSC patients, Aetna is the insurer.

1. This is an action under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and its governing regulations, concerning Aetna's refusal to provide coverage and denial of benefits for a large number of medically necessary procedures performed by PSSC, an out-of-network provider. PSSC also brings state law fraudulent misrepresentation and unjust enrichment claims involving health care plans not subject to ERISA.

2. As alleged below, an investigator for Aetna's Special Investigations Unit ("SIU") purported to have found a "discrepancy" in the claims PSSC had submitted to Aetna related to bariatric surgery being billed together with laparoscopy, since this investigator unilaterally and arbitrarily decided that the laparoscopy was an incidental procedure to bariatric surgery. The investigator did not accuse PSSC of fraudulent billing practices and to this day Aetna has not brought any action against PSSC.

3. Although this unilateral decision was, in fact, contrary to Aetna's own clinical policy for bariatric surgery, as further described below, Aetna's investigator sought to recoup all the monies Aetna had paid for these claims. However, because PSSC was out-of-network, Aetna could not recoup monies from PSSC.

4. Instead, the investigator pended PSSC's claims. This is performed by placing a claims processing code, or "flag," on a provider's account, so that submitted claims are automatically not paid. Upon information and belief, Aetna's claims processing system was – and continues to be – incapable of flagging only certain claims, and consequently all of PSSC's submitted claims were and continue to be denied. Each such denial constituted an adverse benefit determination under ERISA. The amount of denied claims is more than $6 million.

5. In an effort to resolve this matter short of litigation, PSSC's counsel sent a letter to Aetna's counsel and to the investigator setting out the disputed issues and inviting a discussion. Aetna failed to respond, preferring to deny all of PSSC's submitted claims for surgery and other procedures for Aetna's members.

JURISDICTION

6. The Court has subject matter jurisdiction over PSSC's ERISA claims under 28 U.S.C. § 1331 (federal question jurisdiction), and supplemental jurisdiction over PSSC's state-law claims.

7. The Court has personal jurisdiction over the parties because Plaintiffs submit to the jurisdiction of this Court, and each Defendant systematically and continuously conducts business in this State, and otherwise has minimum contacts with this State sufficient to establish personal jurisdiction over each of them.

8. Venue is appropriately laid in this District under 28 U.S.C. § 1391 because (a) Aetna resides, is found, has an agent, and transacts business in this District and (b) Aetna conducts a substantial amount of business in this district, including marketing, advertising and selling insurance products, and insures and administers group healthcare insurance plans both inside and outside this District, including from offices located in this District; and (c) the Plan Defendants transact business in this District.

PARTIES

9. Plaintiff Puget Sound Surgical Center's principal place of business is 21911 76th Avenue West, Edmonds, Washington 98026.

10. Defendant Aetna is an insurance company that provided both risk-based insurance to fully insured plans and third-party administration services to self-funded plans, including to the Plan Defendants. Aetna's corporate headquarters were located at 151 Farmington Avenue, Hartford, Connecticut 06156. Aetna reportedly is relocating to New York City. By administering the Plan Defendants' plans, including by making coverage and benefit decisions and deciding appeals, Aetna is a fiduciary as defined by ERISA.

11. Defendant Bank of America is incorporated in Delaware and is the plan sponsor of the self-funded Group Benefits Program under which certain of PSSC's patients receive health care coverage. (The names and other personal health information ["PHI"] is omitted here and will be made available in full to Aetna and as appropriate to the Plan Defendants in discovery once a HIPAA Confidentiality Order is entered by the Court.) Bank of America's Corporate Benefits Committee is the plan administrator. Bank of America's corporate headquarters is 100 North Tryon Street, Charlotte Street, North Carolina 28255.

12. Defendant State of Alaska AlaskaCare Employee Health Plan is a Group Benefits Program under which certain of PSSC's patients receive health care coverage. Its address is 333 Willoughby Avenue, 6th floor, Juneau, AK 99801. Aetna is the medical claims administrator for this plan.

13. Defendant Amtrak Health Care Plan is a Group Benefits Program under which certain of PSSC's patients receive health care coverage. Its address is 60 Massachusetts Avenue NE, Washington DC 20002.

14. Defendant Anchorage School District Active Employee Open Choice PPO Medical Plan is a self-funded Group Benefits Program under which certain of PSSC's patients receive health care coverage. Its address is 5530 East Northern Lights Blvd., Anchorage, AK 99504.

15. Defendant Bechtel Jacobs Company LLC Health and Welfare Benefit Plan is a Group Benefits Program under which certain of PSSC's patients receive health care coverage. Its address is Highway 58, Blair Road, East Tennessee Technology Park, Oak Ridge, TN 32831.

16. Defendant Nordstrom, Inc. Classic Plan is a Group Benefits Program under which certain of PSSC's patients receive coverage. Its address is 1617 6th Avenue, Seattle, WA 98101.

17. Defendant Starbucks Health Care Plan is a Group Benefits Program under which certain of PSSC's patients receive coverage. Its address is 2401 Utah Avenue South, Seattle, WA 98134.

18. Defendant Costco Wholesale Health Plan is a Group Benefits Program under which certain of PSSC's patients receive coverage. Its address is 999 Lake Drive, Issaquah, WA 98027.

19. Defendant Sound Health and Wellness Trust Plan is a Group Benefits Program under which certain of PSSC's patients receive coverage. Its address is 201 Queen Anne Avenue N, #100, Seattle, WA 98109.

20. Defendant WESTCO Health Plan is a Group Benefits Program under which certain of PSSC's patients receive coverage. Its address is 6875 South 900 East, Suite 700, Midvale, UT 84047.

21. Defendant Lockheed Martin Corporation Total Health Plan is a Group Benefits Program under which certain of PSSC's patients receive coverage. The address of the plan sponsor and administrator is 6801 Rockledge Drive, Bethesda, MD 20817.

22. Defendant Adobe Systems, Inc. Group Welfare Plan is a Group Benefits Program under which certain of PSSC's patients receive coverage. The address is 345 Park Avenue, San Jose, CA 95110.

FACTUAL ALLEGATIONS

23. On May 5, 2016, Deborah J. Giorgetti, the Aetna SIU investigator, sent a letter to plaintiff PSSC stating that she had completed a review of claims PSSC had submitted to Aetna. Giorgetti purported to identify a "discrepancy that *may have* resulted in an overpayment." She further stated that a medical director, whom she refused to identify, contended that CPT code 43281 (laparoscopy, surgical, repair of esophageal hernia) was either billed alone for bariatric surgery (gastric sleeve) or billed together with bariatric surgery and CPT code 43775-59. This anonymous medical director contended that laparoscopy was an incidental procedure to bariatric surgery and should not have been separately reimbursed by Aetna.

24. Laparoscopy is a surgical procedure with its own separate CPT code in which a fiber-optic instrument is inserted through the abdominal wall to view the organs in the abdomen. Modifier -59 is used to indicate that a procedure or service was distinct or independent from other services performed on the same day. Its use is described in detail in the National Correct Coding Initiative ("NCCI").

25. Laparoscopy is not an incidental procedure to a gastric sleeve procedure and both surgical procedures were billed correctly using the -59 modifier. In fact, laparoscopy is a more complex surgical procedure.

26. Giorgetti represented that the time frame for Aetna's adjudication of PSSC's claims would be "extended," without any further indication of a timetable. She denied that the claims were being "held." Significantly, she referred to PSSC's non-existent provider contract, which she said required PSSC "to cooperate with Aetna to secure the return of any overpayment or payment made in error, and to forward to Aetna within a reasonable time any such overpayment."

27. At no point did Giorgetti, despite PSSC's submission of medical records and appeals, evaluate the merits of its particular claims based on the medical records, as promised. She did not state that there was a discrepancy, only that there "may" have been. Nonetheless, Giorgetti placed a flag on PSSC's account with Aetna such that no claims were reimbursed going forward.

28. A flag is a processing code appended to a provider's account that instructs the normal auto-adjudication of claims to deny all claims and append certain denial codes to the Explanation of Benefits ("EOB"). These denial codes do not accurately reflect the reason for the denial, however, which is that the computerized software is instructed to deny the claims.

29. Health care insurers, like Aetna, flag providers through their SIU when they cannot force recoupments. When Giorgetti discovered that PSSC was out-of-network and that it was too difficult to recoup from it (notwithstanding there was no basis whatsoever to do so), she simply entered a processing code into Aetna's system that resulted in Aetna's denial of all of PSSC's claims – not limited to the laparoscopy-bariatric surgery issue that ostensibly was the sole focus of her investigation.

30. Aetna's SIU has a financial incentive to pend and deny claims, since it reports amounts "saved" from reimbursing PSSC and other providers directly to Aetna management. It has a monthly and yearly budget of savings it must generate and executive compensation, including the personal compensation of the investigators, is based on making these numbers.

31. In her May 5, 2016 letter, Giorgetti represented that she did not pend or hold claims. This was a misrepresentation. Placing a flag on PSSC's claims pends them – until the flag is removed. Under ERISA, this is an adverse benefit determination, under which Giorgetti's conduct exposed Aetna to liability for prompt pay interest.

32. On June 30, 2016, PSSC responded to Giorgetti's May 5, 2016 letter, supplementing a telephone conversation she had with the head of PSSC's billing department. PSSC advised Giorgetti that CPT code 43281 is not incidental to CPT code 43775 and modifier -59 was properly used to identify each separate and distinct procedure under the NCCI.

33. On July 15, 2016, Giorgetti ignored PSSC's reference to NCCI – which is the industry standard – and responded that "Aetna's policies regarding the handling of CPT code 43281 is [sic] similar to several other major insurance companies." In other words, although Aetna's policies were baseless and found nowhere in any plan or Summary Plan Description ("SPD"), other insurers were doing it.

34. Giorgetti also stated that Aetna had a Clinical Policy for the medical necessity of bariatric surgery and that "[t]here are a few CPT codes in which CPT code 43281 is not acceptable, including 43775.

35. Upon information and belief, the Clinical Policy Giorgetti referred to is entitled "Obesity Surgery" (No. 0157). It does not state that CPT code 43281 is incompatible with CPT code 43775.

36. Giorgetti also referred to another surgical issue involving PSSC: hernia repair discovered during the course of a laparoscopic gastric procedure. She took the unilateral position that surgical repair of a hernia was incidental to gastric surgery unless the hernia was found before the bariatric surgery was documented.

37. There is no legitimate basis for such a position. And it is doubly ironic since Giorgetti's position was that the laparoscopic gastric surgery was incidental to another surgical procedure (bariatric surgery), such that if Giorgetti were to be believed the hernia repair would be incidental to another incidental procedure. As a consequence of this CPT code shell game, Aetna would never pay for anything since every procedure was incidental to every other procedure.

38. As a matter of medical coding – and common sense – there is also no basis to call a hernia surgical repair incidental when discovered in the course of gastric surgery – when the surgeon can clearly see and then repair the hernia – but not incidental only when a physician can see a hernia protruding from a patient's (clothed) body. And even more remarkable is Giorgetti's position that the hernia repair would not be incidental if the surgeon performing the laparoscopic gastric surgery saw the hernia *and did nothing other than document it* and closed up the patient. Then, a few days later, if the same surgeon opened up the patient again and repaired the hernia (with all the attendant surgical and anesthesia risks), ostensibly this surgery would be separately reimbursable. But no surgeon would ethically do such a thing.

39. The remainder of Giorgetti's July 15, 2016 letter are even more troubling. Contrary to her representations in the May 5, 2016 letter, she stated that all PSSC claims with CPT codes billed on the same day as CPT code 43281 will be pended by the SIU, and that "claims are pended for review" by other departments. This concession demonstrates that Giorgetti's initial denial that she had ever pended PSSC's claims were false and fraudulent when made.

40. On September 16, 2016, PSSC's outside counsel sent a letter to Giorgetti setting out the number of claims pended as of that time and their value and demanded that they be processed and paid. Giorgetti refused to respond.

41. On November 26, 2016 Aetna sent a recoupment demand to PSSC for $40,000 involving the same 43281/43775 issue. PSSC denied this demand on December 19, 2016.

42. On June 19, 2017, PSSC's new outside counsel sent a letter to Giorgetti and Aetna's West Region General Counsel Mary V. Anderson setting out the above and the claims at issue and inviting the parties to resolve the issues short of litigation. Once again, Aetna refused to respond.

The Explanation of Benefits

43. In hundreds of EOBs, Aetna attempted to cover up the fact that it was denying all of PSSC's claims by invoking adjustment codes and remark codes that do not factually describe the real reason for the denials. As put into motion by Giorgetti, they constitute fraud on the part of Aetna and adverse benefit determinations under ERISA.

44. Although some plans do not cover bariatric surgery, none of these plans are at issue in this case, and for each PSSC patient their plans do cover bariatric surgery (and hernia repair). None make any reference to how bariatric surgery, laparoscopy, or hernia repair, is coded, or whether one procedure is incidental to another. Nor is the medical necessity of the bariatric surgery at issue, since Aetna reimbursed PSSC for one of the bariatric surgical procedures, although incompletely.

45. In numerous EOBs sent to PSSC, Aetna under-reimbursed PSSC or denied the claim entirely when PSSC billed under CPT code 43774 (laparoscopy, surgical, removal of adjustable gastric restrictive device and subcutaneous port components). Aetna used the adjustment code PR-96 and remark code N130.

46. PR-96 states: "Non-covered charge. At least one remark code must be provided (may be comprised of either the NCPDP reject reason code or remittance advice remark code that is not an alert). Note: Refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF), if present.

47. N130 states: Consult plan benefit document/guidelines for information about restrictions for this service.

48. The language of PR-96 is gibberish. It provides no basis to deny or under-reimburse payment of this surgical procedure. N130 is inadequate under ERISA and the rules promulgated under ERISA. Under 29 CFR § 2560.503-1, adverse benefit determinations must include required disclosures, which include the specific reason(s) for the denial of a claim, reference to the specific plan provisions on which the benefit determination is based, and a description of the plan's appeal procedures. PR-96 and N130 provide none of these required disclosures.

49. At other times, Aetna denied laparoscopy billed under CPT code 43774 as experimental and investigational, using adjustment code PI-55 and remark code N623. Laparoscopy is not experimental and investigational, as evidenced by, among other things, Aetna's conclusion in other EOBs that it was medically necessary (although denied for other reasons). Laparoscopy is described as a covered, medically necessary surgical procedure in Aetna's clinical bulletins, including "Obesity Surgery." Denying this procedure as experimental and investigational was a pretext for flagging the claim by Aetna's SIU.

50. In other EOBs, Aetna denied or under-reimbursed claims using adjustment code PR-45, which states: "Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement."

51. Since PSSC is and has always been out-of-network with Aetna, there is no fee schedule or contracted fee arrangement, which is exclusively an arrangement for in-network providers. There is no legislated fee arrangement at issue here, and no maximum allowable amount for covered bariatric surgery.

52. Aetna denied reimbursement for other procedures in addition to those described above as incidental to another procedure. It unilaterally determined that an esophagogastroduodenoscopy, CPT code 43235, was incidental to CPT code 43774. As discussed above, Giorgetti's unilateral position was that laparoscopy was incidental to bariatric surgery. In any event, endoscopy and laparoscopy are separately compensable procedures.

53. In a number of EOBs, Aetna denied PSSC's claims using the code for "payor initiated reductions" which states: "Use this code when in the opinion of the payer the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e. medical review or professional review organization adjustments)."

54. Payor initiated reductions is SIU-talk for the denial of claims when an out-of-network provider is flagged. It is further evidence that Giorgetti's statements that PSSC's claims would not be held and would be paid upon receipt of medical records were false and fraudulent when made.

55. In a number of instances, Aetna denied reimbursement for CPT code 99213 (evaluation and management of an established patient) as incidental to a surgical procedure. An office visit is not incidental to a surgical procedure unless, unlike here, a provider agreed to this type of reimbursement.

56. In other instances, Aetna denied reimbursement for CPT code 99203 (evaluation and management of a new patient) under N-95 and PL-170 because PSSC cannot bill for this service.

57. PSSC may bill for the evaluation and management of a new patient. Denying reimbursement for these claims functions, again, as a pretext for the flagging of PSSC's claims.

58. In some instances Aetna denied claims under adjustment code OA: "other adjustments" which means nothing, and OA-252: "an attachment/other documentation is required to adjudicate this claim/service" without actually specifying what attachment or documentation was required. Such an explanation fails the requirements of 29 CFR § 2560.503-1.

59. Other instances are demonstrably wrong. Aetna denied claims based on the adjustment code CO, for "contractual obligations." "Use this code when a joint payer/payee contractual agreement or a regulatory requirement resulted in an adjustment." There is no contractual agreement because PSSC is out-of-network and there is no regulatory requirement that Aetna deny PSSC's claims. Nor is there any contractual agreement between Aetna and the plan member requiring an adjustment or denial of PSSC's claims.

60. In another instance, PSSC's claims for reimbursement for CPT codes 43281 and 43775 were denied as *both* not covered and incidental to each other, which is mutually inconsistent.

61. In another instance, Aetna denied a claim for bariatric surgery billed under CPT code 43281 as medically unnecessary, but denied CPT code 43775 not itself as medically unnecessary but as incidental to 43281 – which it contended as medically unnecessary. Since the denial of a surgical procedure as incidental to a medically unnecessary surgical procedure is contradictory as a matter of common sense – and frankly Kafkaesque – the only conclusion to be

drawn is that it was another example of the SIU covering up its flagging of PSSC's claims and the adverse benefit determinations under ERISA.

62. Aetna denied PSSC's billing for nutrition counseling billed under CPT code 97802 as a non-covered charge. Nutrition counseling (as is psychological counseling) is required of all patients prior to undergoing bariatric surgery (excess intake of food may result in the gastric sleeve over-expanding). When bariatric surgery is a covered expense, nutrition counseling must be.

63. There is one claims processing example found in an EOB that is correct and is alleged here to demonstrate how the remainder of the claims should be re-processed. PSSC billed for CPT 49321 (laparoscopy procedure on the abdomen, peritoneum and omentum with biopsy) and CPT code 43644 (laparoscopy, surgical, gastric bypass and Roux-en-Y gastroenterostomy), as well as CPT code 43281. Aetna reimbursed CPT code 43281 under the multiple surgery rule.

64. This was the correct processing procedure. When more than one surgery is performed on the same date of service the multiple surgery rule may apply. When PSSC surgeons performed a laparoscopic gastric procedure and hernia repair, the proper claims processing methodology was to have reimbursed the laparoscopic gastric procedure and applied the multiple surgery rule to the hernia repair surgical procedure, not deemed the hernia repair surgery incidental to the laparoscopic gastric procedure. The identical methodology should have been applied to PSSC's billing for laparoscopy and bariatric surgery – the so-called "discrepancy" that began the investigation resulting in the flagging of PSSC's claims and this litigation.

65. For example, Aetna bundled CPT codes 49040 (drainage of sub diaphragmatic or sub phrenic abscess), 44300 (placement, enterostomy or cesotoby, tube open), 39501 (repair, laceration of diaphragm), 38100 (splenectomy), and 32551 (tube thoracostomy). These surgical

procedures are not incidental to one procedure and should not be bundled. Rather, they should be subject to the multiple surgery rule.

Specific Examples

66. By way of examples, for service date June 1, 2016 and patient KE, PSSC billed Aetna $20,000 under CPT code 43281. Using codes PR-45 and N130, Aetna reimbursed PSSC $3,200. The insured is an Amtrak employee, and under the Amtrak SPD the self-funded Amtrak plan places no restrictions on bariatric surgery and pays the reasonable and customary fees for this procedure (not the maximum allowable amount).

67. Significantly, in an EOB issued by Aetna for the same service date and the same patient in which PSSC billed $60,000 and Aetna paid nothing, stating "these expenses require further review," just below the taxpayer number Aetna wrote: "NO PAY."

68. For service date February 12, 2015 and patient CC, PSSC billed $40,000 under CPT codes 43281 and 43775. Using codes N19 and PR-45, Aetna reimbursed PSSC $920.65. Patient CC is insured under the Aetna Open Access plan.

69. For service date April 7, 2017 and patient MR, PSSC billed $150 under CPT code 94690 (oxygen uptake, expired gas analysis) and Aetna paid nothing. The insured is a member of the Anchorage School District Active Employee Open Choice PPO Medical Plan, which is a non-ERISA plan. The Plan document says nothing about Aetna's right to flag or pend claims.

70. For service date August 4, 2016 and patient KH, PSSC billed $631 under CPT codes 99205 and 93000 (evaluation and management of new patient and electrocardiogram) and Aetna paid nothing. The insured is a member of the Bank of America health care plan, a self-funded plan.

71. For service date September 11, 2014 and patient RB, PSSC billed $40,000 under CPT code 43775 and Aetna paid $4,770.50. The insured is a member of the Bechtel Jacobs Company LLC Health and Welfare Benefit Plan.

72. For service date April 12, 2016 and patient JD, PSSC billed $41,540 under CPT codes 43775, 43821 and 43235 and Aetna paid $7,086.11, using N130 and PR-45. Because two surgeons were involved, PSSC billed $40,000 using modifier -62 and was paid $6,251. Aetna took the position the procedure was incidental to the primary procedure, and the charge exceed the non-existent fee schedule. For service date August 26, 2015 and patient NP, PSSC billed $70,450 under CPT codes 44180, 43775 and 43235 and Aetna paid $20,520. Patients JD and NP are members of the State of Alaska AlaskaCare Employee Health Plan. The Commissioner is the Plan Administrator. The plan covers bariatric surgery and says nothing about flagging or pending claims.

73. For service dates April 24-25, 2017 and patient KK, PSSC billed $230,000 for a large number of separate surgical procedures under CPT codes 43775, 43281, 96361, and 96360. Aetna paid nothing. The patient is a beneficiary of the Nordstrom, Inc. Classic Plan.

74. For service dates November 2, 2016, January 23, 2017, and March 15, 2017 and patient GC, PSSC billed for a number of procedures under CPT codes 43239 (esophagogastroduodenoscopy), 43774, 43775, and 43281. For the endoscopy procedure PSSC billed $7,500 and Aetna paid $640. For the laparoscopy, PSSC billed $20,000 and Aetna paid $1,007.41; for the co-surgeon Aetna paid $161.18. For the remaining surgical procedures in which PSSC billed $75,000 each, Aetna paid nothing, leaving an unpaid balance of $196,592. The patient is a beneficiary of the Starbucks Health Care Plan.

75. For service dates May 7, 2014 and July 13, 2016 and patient VA, PSSC billed under CPT code 43775. For one procedure, Aetna paid $5,625.90, leaving a balance of $14,374.10. For a second procedure, billed for $75,000, Aetna paid $45,597.01, leaving a balance of $29,502.99. For a third procedure billed for $40,000, Aetna paid $14,102, leaving a total unpaid balance of $57,879.09. The patient is a beneficiary of the Costco Wholesale Health Plan.

76. For a number of service dates and patients RA, SA, HD, KM. CR, JS, and AW, Aetna's lack of payments left an unpaid balance of $186,018.49. These patients are beneficiaries of the Sound Health and Wellness Trust.

77. For service date November 1, 2016 and patient RM, PSSC billed $115,000 under CPT code 43775 (including for a co-surgeon). Aetna paid $49,825.52, leaving an unpaid balance of $64,827.08. The patient is a beneficiary of the WESTCO Health Plan.

78. For service date April 12, 2016 and patient MC, PSSC billed $40,000 under CPT code 43644 (laparoscopy, gastric bypass and Roux-en-Y gastroenterostomy), for which Aetna paid $4,176.30, leaving an unpaid balance of $35,827.70. The patient is a beneficiary of the Lockheed Martin Corporation Total Health Plan.

79. For service dates April 10-13, 2017 and patient BA, PSSC billed $282,204 under CPT codes 43235, 49657, 43775, 43281, 43775, 96361, 96360, 99213 and 73610. Aetna paid nothing. The patient is a beneficiary of the Sarasota County Government Aexcel Plus Aetna Choice POS II Health Care Plan.

80. For service dates April 28, 2015 and March 21, 2016 and patient TS, PSSC billed $145,000 under CPT codes 43281 and 15830, for which Aetna paid $49,126.24, leaving an unpaid balance of $98,389.70. For service dates April 28, 2015 and June 28, 2015 and patient LT, PSSC

billed $30,281 under CPT codes 15847 and 99214. Aetna paid nothing. The patients are beneficiaries of the Adobe Systems, Inc. Group Welfare Plan.

81. PSSC took assignments of these claims from its patients.

82. PSSC exhausted its administrative remedies by appealing the denials or under-reimbursements of each of these claims and receiving a denial of these appeals (or Aetna's failure to respond). Alternatively, exhaustion is futile because Aetna's appeals staff do not have permission to overrule the determination to deny, pend, and flag claims made by the SIU department. Further, as alleged above, PSSC sought to exhaust its remedies by appealing to the SIU unit, which was responsible for the non-payment and under-reimbursement of its claims, and was rebuffed. Consequently, this litigation is the only avenue open to it. In addition, under Washington law, failure to adhere to the statutory review requirements results in deemed exhaustion.

COUNT I

CLAIM AGAINST AETNA FOR UNPAID BENEFITS UNDER EMPLOYEE BENEFIT PLAN GOVERNED BY ERISA

83. As the claims administrator for the Plan Defendants, and as a plan fiduciary because it retains discretion in interpreting the terms of the plan and determines appeals, Aetna must cover and pay benefits to members of the Plan Defendants and fully insured members in accordance to the terms of the plan, and in accordance with ERISA.

84. Aetna violated its legal obligations under the ERISA-governed plans when it denied and under-reimbursed the surgical and other procedures and services PSSC billed to it as described in this Complaint, in violation of ERISA § 502(a)(l)(B), 29 U.S.C. § 1132(a)(l)(B).

85. Plaintiff seeks unpaid benefits, prompt pay interest, and statutory interest back to the date her claim was originally submitted to Aetna. She also seeks attorneys' fees, costs, prejudgment interest and other appropriate relief against Aetna.

COUNT II

CLAIM AGAINST BANK OF AMERICA FOR UNPAID BENEFITS UNDER EMPLOYEE BENEFIT PLAN GOVERNED BY ERISA

86. As the plan administrator and sponsor for the Bank of America plan, Bank of America must cover and pay benefits to Bank of America plan members in accordance to the terms of the plan, and in accordance with ERISA. Bank of America violated its legal obligations under this ERISA-governed plan when, through its third-party administrator, Aetna, it denied and under-reimbursed the surgical and other procedures and services PSSC billed to Aetna as described in this Complaint, in violation of ERISA § 502(a)(l)(B), 29 U.S.C. § 1132(a)(l)(B).

87. Plaintiff seeks unpaid benefits, prompt pay interest, and statutory interest back to the date her claim was originally submitted. It also seeks attorneys' fees, costs, prejudgment interest and other appropriate relief against Bank of America.

COUNT III

CLAIM AGAINST AMTRAK HEALTH CARE PLAN FOR UNPAID BENEFITS UNDER EMPLOYEE BENEFIT PLAN GOVERNED BY ERISA

88. As the plan administrator and sponsor for the Amtrak Health Plan, the Plan must cover and pay benefits to plan members in accordance to the terms of the plan, and in accordance with ERISA.

89. Amtrak Health Care Plan violated its legal obligations under this ERISA-governed plan when, through its third-party administrator, Aetna, through its third-party administrator, Aetna, it denied and under-reimbursed the surgical and other procedures and services PSSC billed

to Aetna as described in this Complaint, in violation of ERISA § 502(a)(l)(B), 29 U.S.C. § 1132(a)(l)(B).

90. Plaintiff seeks unpaid benefits, prompt pay interest, and statutory interest back to the date her claim was originally submitted. It also seeks attorneys' fees, costs, prejudgment interest and other appropriate relief against Amtrak Health Care Plan.

COUNT IV

CLAIM AGAINST BECHTEL JACOBS COMPANY LLC HEALTH AND WELFARE BENEFIT PLAN FOR UNPAID BENEFITS UNDER EMPLOYEE BENEFIT PLAN GOVERNED BY ERISA

91. As the plan administrator and sponsor for the Bechtel Jacobs Company LLC Health and Welfare Benefit Plan, the Plan must cover and pay benefits to plan members in accordance to the terms of the plan, and in accordance with ERISA.

92. Bechtel Jacobs Company LLC Health and Welfare Benefit Plan violated its legal obligations under this ERISA-governed plan when, through its third-party administrator, Aetna, it denied and under-reimbursed the surgical and other procedures and services PSSC billed to Aetna as described in this Complaint, in violation of ERISA § 502(a)(l)(B), 29 U.S.C. § 1132(a)(l)(B).

93. Plaintiff seeks unpaid benefits, prompt pay interest, and statutory interest back to the date her claim was originally submitted. It also seeks attorneys' fees, costs, prejudgment interest and other appropriate relief against Bechtel Jacobs Company LLC Health and Welfare Benefit Plan.

COUNT V

CLAIM AGAINST NORDSTROM, INC. CLASSIC PLAN FOR UNPAID BENEFITS UNDER EMPLOYEE BENEFIT PLAN GOVERNED BY ERISA

94. As the plan administrator and sponsor for the Nordstrom, Inc. Classic Plan, the Plan must cover and pay benefits to plan members in accordance to the terms of the plan, and in accordance with ERISA.

95. Nordstrom, Inc. Classic Plan violated its legal obligations under this ERISA-governed plan when, through its third-party administrator, Aetna, it denied and under-reimbursed the surgical and other procedures and services PSSC billed to Aetna as described in this Complaint, in violation of ERISA § 502(a)(l)(B), 29 U.S.C. § 1132(a)(l)(B).

96. Plaintiff seeks unpaid benefits, prompt pay interest, and statutory interest back to the date her claim was originally submitted. It also seeks attorneys' fees, costs, prejudgment interest and other appropriate relief against Nordstrom, Inc. Classic Plan.

COUNT VI

CLAIM AGAINST STARBUCKS HEALTH CARE PLAN FOR UNPAID BENEFITS UNDER EMPLOYEE BENEFIT PLAN GOVERNED BY ERISA

97. As the plan administrator and sponsor for the Starbucks Health Care Plan, the Plan must cover and pay benefits to plan members in accordance to the terms of the plan, and in accordance with ERISA.

98. Starbucks Health Care Plan violated its legal obligations under this ERISA-governed plan when, through its third-party administrator, Aetna, it denied and under-reimbursed the surgical and other procedures and services PSSC billed to Aetna as described in this Complaint, in violation of ERISA § 502(a)(l)(B), 29 U.S.C. § 1132(a)(l)(B).

99. Plaintiff seeks unpaid benefits, prompt pay interest, and statutory interest back to the date her claim was originally submitted. It also seeks attorneys' fees, costs, prejudgment interest and other appropriate relief against Starbucks Health Care Plan.

COUNT VII

CLAIM AGAINST COSTCO WHOLESALE HEALTH PLAN FOR UNPAID BENEFITS UNDER EMPLOYEE BENEFIT PLAN GOVERNED BY ERISA

100. As the plan administrator and sponsor for the Costco Wholesale Health Plan, the Plan must cover and pay benefits to plan members in accordance to the terms of the plan, and in accordance with ERISA.

101. Costco Wholesale Health Plan violated its legal obligations under this ERISA-governed plan when, through its third-party administrator, Aetna, it denied and under-reimbursed the surgical and other procedures and services PSSC billed to Aetna as described in this Complaint, in violation of ERISA § 502(a)(l)(B), 29 U.S.C. § 1132(a)(l)(B).

102. Plaintiff seeks unpaid benefits, prompt pay interest, and statutory interest back to the date her claim was originally submitted. It also seeks attorneys' fees, costs, prejudgment interest and other appropriate relief against Costco Wholesale Health Plan.

COUNT VIII

CLAIM AGAINST LOCKHEED MARTIN CORPORATION TOTAL HEALTH PLAN FOR UNPAID BENEFITS UNDER EMPLOYEE BENEFIT PLAN GOVERNED BY ERISA

103. As the plan administrator and sponsor for the Lockheed Martin Corporation Total Health Plan, the Plan must cover and pay benefits to plan members in accordance to the terms of the plan, and in accordance with ERISA.

104. Lockheed Martin Corporation Total Health Plan violated its legal obligations under this ERISA-governed plan when, through its third-party administrator, Aetna, it denied and under-reimbursed the surgical and other procedures and services PSSC billed to Aetna as described in this Complaint, in violation of ERISA § 502(a)(l)(B), 29 U.S.C. § 1132(a)(l)(B).

105. Plaintiff seeks unpaid benefits, prompt pay interest, and statutory interest back to the date her claim was originally submitted. It also seeks attorneys' fees, costs, prejudgment interest and other appropriate relief against Lockheed Martin Corporation Total Health Plan.

COUNT IX

CLAIM AGAINST ADOBE SYSTEMS, INC. GROUP WELFARE PLAN FOR UNPAID BENEFITS UNDER EMPLOYEE BENEFIT PLAN GOVERNED BY ERISA

106. As the plan administrator and sponsor for the Adobe Systems, Inc. Group Welfare Plan, the Plan must cover and pay benefits to plan members in accordance to the terms of the plan, and in accordance with ERISA.

107. Adobe Systems, Inc. Group Welfare Plan violated its legal obligations under this ERISA-governed plan when, through its third-party administrator, Aetna, it denied and under-reimbursed the surgical and other procedures and services PSSC billed to Aetna as described in this Complaint, in violation of ERISA § 502(a)(l)(B), 29 U.S.C. § 1132(a)(l)(B).

108. Plaintiff seeks unpaid benefits, prompt pay interest, and statutory interest back to the date her claim was originally submitted. It also seeks attorneys' fees, costs, prejudgment interest and other appropriate relief against Adobe Systems, Inc. Group Welfare Plan.

COUNT X

IMPLIED-IN-LAW CONTRACT/UNJUST ENRICHMENT

109. PSSC conferred as direct benefit upon Aetna and Plan Defendants Anchorage and Alaska (the "non-ERISA Defendants") by providing valuable, covered, and medically necessary health care services to Aetna's subscribers and the non-ERISA Defendants' employees with the express authorization and approval of Aetna or through the established course of dealing as the party responsible for payment for these health care services.

110. As the responsible party for providing access to its subscribers and employees for payment, Aetna and the non-ERISA Defendants derived a direct benefit from PSSC's provision of these health care services for its subscribers and employees because PSSC provided the health care services at its own expense by which Aetna and the non-ERISA Defendants fulfilled their contractual obligations to each other and to their subscribers and employees who pay premiums.

111. Aetna and the non-ERISA Defendants voluntarily accepted, retained, and enjoyed the benefits conferred by PSSC, at PSSC's expense, with the knowledge that PSSC expected to be paid the value of its services.

112. Aetna failed to pay the value of PSSC's health care services. Utilizing its claims processing software, it first under-reimbursed PSSC's claims and then denied every claim for every date of service for every procedure. Aetna retained the funds it would otherwise have reimbursed PSSC.

113. Aetna also did so by failing to follow the requirements of Washington law. WAC 284-43-3070 requires that a carrier or health plan's notice must include the following information, worded in plain language:

a. (a) The specific reasons for the adverse benefit determination;

b. (b) The specific health plan policy or contract sections on which the determination is based, including references to the provisions;
c. (c) The plan's review procedures, including the appellant's right to a copy of the carrier and health plan's records related to the adverse benefit determination;
d. (d) The time limits applicable to the review; and
e. (e) The right of appellants and their providers to present evidence as part of a review of an adverse benefit determination.

114. Aetna denials and flagging of claims included none of the above required information.

115. WAC 284-43-3150 states: "In addition to the requirements of WAC 284-43-3070, the written determination must include:

a. (1) The actual reasons for the determination;
b. (2) If applicable, instructions for obtaining further review of the determination, either through a second level of internal review, if applicable, or using the external review process;
c. (3) The clinical rationale for the decision, which may be in summary form; and
d. (4) Instructions on obtaining the clinical review criteria used to make the determination;
e. (5) A statement that the appellant has up to one hundred eighty days to file a request for external review, and that if review is not requested, the internal review decision is final and binding.

116. Aetna included none of the above required information in flagging PSSC's claims.

117. Although PSSC appealed the denial of the flagged claims, Aetna either did not reconsider or ignored the appeal. This was prohibited by WAC 284-43-3110, which requires that the carrier must reconsider the adverse benefit determination: "The carrier must notify the appellant of the review decision within fourteen days of receipt of the request for review, unless the adverse benefit determination involves an experimental or investigational treatment. The carrier must notify the appellant of the review decision within twenty days of receipt of the request

for review when the adverse benefit determination involves an experimental or investigational treatment." This requirement precludes precisely what Aetna is alleged to have done here: pended PSSC's claims without further notification, without further review, and in perpetuity.

118. In addition, Aetna violated WAC 284-170-431, Washington's Prompt Pay law, by failing to pay interest on the flagged claims.

119. Under WAC 284-43-3130, when a carrier fails to adhere strictly to the internal review requirements, the internal review process is deemed exhausted.

120. By failing to reimburse PSSC for health care services rendered to Aetna's subscribers and the "non-ERISA Defendants' employees, these Defendants have been unjustly enriched.

121. Plaintiff seeks unpaid benefits, prompt pay interest, and statutory interest back to the date her claim was originally submitted. It also seeks attorneys' fees, costs, prejudgment interest and other appropriate relief.

COUNT XI

FRAUDULENT MISREPRESENTATION

122. Aetna, through SUI investigator Giorgetti, made a series of fraudulent misrepresentations to PSSC. Relying on these representations, PSSC provided health care services to Aetna's subscribers and billed Aetna for such services.

123. On May 5, 2016, Giorgetti denied that PSSC's claims were being "held." As was evidenced in subsequent concessions (made in her July 15, 2016 letter in which she conceded she had pended PSSC's claims all along), her initial denial was fraudulent when made because she had already flagged PSSC's account which pended all PSSC's claims, resulted in nonpayment, or knew that she intended to pend (or hold) PSSC's claims.

124. In the same letter, Giorgetti represented that she would process PSSC's claims upon submission of medical records. This representation was fraudulent when made because she did not process any of PSSC's claims nor review the medical records submitted to her.

125. In an attempt to cover up the flagging of PSSC's claims, Giorgetti set into motion a claims processing system startling in its fraudulence: rather than explain that Aetna had denied PSSC's claims because it had unjustly (and under ERISA and state law, illegally) pended all its claims, the EOBs contained an increasingly bizarre set of so-called remark codes, described above, that not only had nothing to do with the true nature of the denials but actually contradicted each other. Each and every remark code and explanation for the denial of reimbursement alleged in this complaint is fraudulent.

126. PSSC seeks compensatory damages and punitive damages in an amount permitted by applicable law, in addition to attorneys' fees and costs.

DEMAND FOR JURY TRIAL

PSSC respectfully requests a jury trial on all issues so triable.

WHEREFORE, Plaintiff demands judgment in its favor against Aetna and the Plan Defendants as follows:

(a) Ordering Aetna and the Plan Defendants to recalculate and issue unpaid benefits to Plaintiff;

(b) Declaring that Aetna and the Plan Defendants breached the terms of the Plan Defendants' plans by failing to reimburse Plaintiff;

(c) Awarding Plaintiff the costs and disbursements of this action, including reasonable attorneys' fees, costs and expenses in amounts to be determined by the Court;

(d) Awarding compensatory and punitive damages;

(e) Awarding prompt pay interest;

(f) Awarding prejudgment interest; and

(g) Granting such other and further relief as is just and proper.

Date: July __, 2017

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