**No. _____**

IN THE

# Supreme Court of the United States

IV SOLUTIONS, INC., a California corporation,

*Petitioner,*

v.

PACIFICARE LIFE & HEALTH INSURANCE CO., an Indiana corporation

*Respondent.*

**On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit**

## PETITION FOR A WRIT OF CERTIORARI

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## QUESTION PRESENTED

When a health care insurance company issues an Explanation of Benefits ("EOB") expressly inviting a health care provider to "notify it of additional information clarifying the services and/or charges," and thereafter engages in an extended dialogue with the health care provider regarding the reprocessing of the provider's claims in light of such additional information, does the statute of limitations begin running as a matter of law immediately upon the issuance of that Explanation of Benefits, even though the insurance company, through its representatives, thereafter communicated to the provider on numerous occasions that the provider's claims were still being reviewed and reprocessed?

## PARTIES TO THE PROCEEDING (RULE 14(b)(i))

Petitioner in this Court, Plaintiff-Appellant below, is IV Solutions, Inc., a California corporation.

Respondent in this Court, Defendant-Appellee below, is PacifiCare Life & Health Insurance Co., an Indiana corporation.

## CORPORATE DISCLOSURE STATEMENT (RULE 29.6)

Pursuant to Supreme Court Rule 29.6, Petitioner IV Solutions, Inc., states that there is neither a parent corporation nor a publicly held corporation that owns 10% or more of its stock within the meaning of the rule.

## LIST OF DIRECTLY RELATED PROCEEDINGS IN FEDERAL TRIAL AND APPELLATE COURTS (RULE 14(b)(iii))

The following federal trial and appellate cases are directly related to the case in this Court, within the meaning of Rule 14(b)(iii):

1. United States District Court for the Central District of California; Case No. 2:16-cv-07153-SJO-MRW; *IV Solutions, Inc., Plaintiff v. PacifiCare Life & Health Insurance Co., Defendant*; Date of Entry of Judgment: October 16, 2017.

2. United States Court of Appeals for the Ninth Circuit; Case No.: 17-56609; *IV Solutions, Inc., Plaintiff-Appellant v. PacifiCare Life & Health Insurance Co., Defendant-Appellee*; Date of Entry of Judgment: February 21, 2020.

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Petitioner IV Solutions, Inc. ("IVS") respectfully submits this petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit.

## OPINIONS BELOW

The opinion of the court of appeals affirming the district court has not been published, but is available at 804 Fed.Appx. 497. Pet. App. A, *infra*. The district court's order granting Respondent's Motion for Summary Judgment has not been published, but is available at 2017 WL 4541163. Pet. App. B, *infra*.

## JURISDICTION

The court of appeals filed its memorandum opinion on February 21, 2020. Under this Court's March 19, 2020 Order, "[i]n light of the ongoing public health concerns relating to COVID-19," "the deadline to file any petition for a writ of certiorari due on or after the date of this order is extended to 150 days from the date of the lower court judgment . . ." Pet. App. C, *infra*. Thus, this petition is timely filed. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

## STATUTORY PROVISIONS INVOLVED

Section 337(a) of the California Code of Civil Procedure states in relevant part:

> Within four years:
>
> (a) An action upon any contract, obligation or liability founded upon an instrument in writing . . .

## STATEMENT OF THE CASE

At all times relevant to this action, IVS was a home infusion pharmacy. Respondent PacifiCare Life & Health Insurance Co. ("PacifiCare") is a health insurance company affiliated with United Healthcare Insurance Company ("UHC"). IVS provided services to C.M., one of PacifiCare's members. [ER 781-82, ¶¶ 17-19.]

While health insurance companies have special fee arrangements with so-called "in-network" providers to handle more ordinary care needs, IVS never agreed to be part of PacifiCare's network of providers and never agreed to provide services to PacifiCare's members for the discounted rates negotiated with such provider.

IVS, did, however, enter into agreements with certain third party provider networks: Three Rivers Provider Network ("TRPN" and the "IVS/TRPN Agreement") and MultiPlan (the "IVS/MultiPlan Agreement"), pursuant to which IVS agreed to accept as payment for services provided to patients accessed through the TRPN network 95% of its billed rates and through the MultiPlan network 90% of its billed charges.

PacifiCare thorough its parent company, UHC, entered into its own agreement with MultiPlan, which also allowed PacifiCare to access providers, such as IVS, on the TRPN network. In this case, PacifiCare accessed the TRPN network in connection with the services provided by IVS to C.M. Under its agreement with MultiPlan, PacifiCare obligated itself to pay the discounted TRPN rate when it accessed IVS through the TRPN network, namely 95% of IVS's billed charged.

Having chosen to avail itself of the TRPN discounted rate, IVS was entitled to payment pursuant to its agreement with TRPN. Accordingly, PacifiCare initially paid IVS the discounted rate set forth in that agreement. However, PacifiCare subsequently paid IVS a far lower amount than the 95% of IVS' billed charges required by the IVS/TRPN Agreement. When IVS inquired about these underpayments, PacifiCare, through its representatives, communicated to IVS on numerous occasions – both by email, correspondence and through recorded telephone calls – that IVS's claims were being reviewed and reprocessed. It was not until January 8, 2013, that PacifiCare reversed its earlier position and for the first time unequivocally denied the claims.

On August 21, 2016, within four years of PacifiCare's unequivocal denial of IVS's claims, IVS filed a lawsuit against PacifiCare in Los Angeles Superior Court.

PacifiCare then caused the action to be removed to the United States District Court for the Central District of California, based on diversity jurisdiction.

On October 28, 2016, PacifiCare filed a Motion to Dismiss the complaint (the "Motion to Dismiss"). In support of the Motion to Dismiss, PacifiCare presented the EOBs for Claim Nos. 185, 215 and 245-252, arguing that these EOBs constituted unequivocal denials of IVS's claims, triggering the running of the four-year statute of limitations. Holding that the EOBs did not demonstrate that PacifiCare had unequivocally denied IVS' claims the District Court denied PacifiCare's motion as it related to the breach of written contract claim.

On August 21, 2017, PacifiCare filed a Motion for Summary Judgment (the "MSJ") and supporting

documents, asserting, as it had in it motion to dismiss, that the EOB's for 185, 215 and 245-252 constituted unequivocal denials of the claims, triggering the running of the statute of limitations. The District Court granted summary judgment, finding that the EOB's for the 215, and 245-252 claims constituted unequivocal denials, to trigger the running of the statute of limitations, notwithstanding PacifiCare's invitation to IVS in these EOB's to "please review the procedure codes and notify us if any unusual treatments were performed or if there is additional information clarifying the services and/or charges," and the subsequent communications from PacifiCare stating that it was in fact reviewing and reprocessing these claims.

The Ninth Circuit affirmed this ruling on appeal, reasoning that "Pacificare did not condition its denial of IVS's claims on the receipt of new information, and its willingness to consider such information did not render its denial unequivocal." App. B.

Thus, this case raises the important issue of when a health care provider can – and must – bring suit against a health care insurer to assert a claim for money owed. Under the holdings of the lower courts, a provider's time to bring suit begins running when the insurer issues an EOB setting forth the amount which it has determined it will pay, even when the insurer, in that same EOB, invites the provider to submit additional information and continues to review and reprocess these claims for a lengthy period of time thereafter.

These rulings leave a provider in the position of having to bring suit for fear of its claims becoming time-barred, even as the insurer continues to repro-

cess those claims, and before the insurer has finally and unequivocally denied those claims.

While this case arose under California's statute of limitations provision set forth in California's Code of Civil procedure section 337, every jurisdiction has a statute of limitations limiting the time for health care providers to bring claims against health insurance companies. The Court's guidance on when such statutes of limitation begin running is necessary to bring important clarity, on a nationwide basis, to thousands of health care providers and insurers as to when a health care provider must bring suit or risk losing its claims as time-barred.

## REASONS FOR GRANTING THE PETITION

The Ninth Circuit's decision leaves health care providers around the country in the unenviable positon of having to prematurely sue health insurers on claims that have yet to be fully, finally, and unequivocally adjudicated by the health insurer or risk losing those claims altogether to the bar of the statute of limitations.

Certiorari is necessary to enable this court to bring clarity – to health care providers and insurers alike – that until a health care provider's claim has been unequivocally denied, the statute of limitations does not begin running, and that the issuance of an EOB alone does not trigger the running of the statute of limitations as a matter of law, particularly where, as here, the EOB expressly invites the provider to submit additional further information and the insurer goes on to review and reprocess the claims, making clear that, notwithstanding the issuance of the EOB, there had been no unequivocal denial of the claims.

The smooth operation of the health care industry depends on both health care providers, and health care insurers, having a clear understanding of when a potential claim for payment has accrued and when the statute of limitation on such claim has begun running.

The opinions of the Ninth Circuit and District Court sow significant confusion in this regard. Under these rulings, the statute of limitations on a provider's claim for payment appears to begin running as a matter of law upon the issuance of an EOB from the provider even when the EOB expressly solicits additional information regarding the claim, inviting the provider to "notify us if any unusual treatments were performed or if there is additional information clarifying the services and/or charges."

Under these rulings, the claims are deemed to have accrued and the statute of limitations to have begun running, even as the provider provides the additional information requested and the insurer continues to process the claims based on that additional information.

This places the provider in the untenable position of potentially having to file a lawsuit to protect its rights, before the insurer has even made a final determination whether it will pay the claim. Forcing providers to resort to court process before claims have been fully adjudicated by health care providers results in an unnecessary waste of judicial resources, unnecessarily disrupts the relationship between the provider and the insurer, and potentially disrupts the continued provision of services by that provider to that insurer's other plan members, all to the detriment of the ultimate end users of these services: the patients requiring treatment.

Certiorari is necessary to permit this Court to introduce much needed clarity on this important issue, which affects health care providers, insurers, and patients alike throughout the United States.

Through certiorari, the Court can and should make clear that: (1) the statute of limitations on a health care provider's claim for payment does not beginning running until the insurer unequivocally denies the provider's claim; and (2) the issuance of an Explanation of Benefits, on its own, does not necessarily constitute an unequivocal denial as a matter of law, particularly where the insurer, through the EOB, invites the provider to provide further information and reprocesses the claims in light of such further information.

This case thus presents an issue of nationwide importance that should be reviewed.

## CONCLUSION

For the foregoing reasons, Petitioner respectfully submits that the petition for a writ of certiorari should be granted.

Respectfully submitted.

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