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SUPERIOR COURT FOR THE STATE OF CALIFORNIA

FOR THE COUNTY OF ALAMEDA

CALIFORNIA CHIROPRACTIC ASSOCIATION, on behalf of itself and its members, Plaintiff, vs. MEDRISK, LLC; MEDRISK HOLDCO, LLC; and DOES 1 through 10, inclusive, Defendants.	CASE NO. RG19045051 Hon. Brad Seligman **FIRST AMENDED COMPLAINT FOR INJUNCTIVE RELIEF FOR VIOLATION OF CALIFORNIA BUSINESS & PROFESSIONS CODE SECTIONS 17200, *et. seq.***

Plaintiff California Chiropractic Association ("Cal Chiro" or "Plaintiff"), by and through the undersigned attorneys, files this First Amended Complaint against Defendants MedRisk, LLC and MedRisk Holdco, LLC (hereafter collectively "MedRisk," except where otherwise indicated) and DOES 1-10, inclusive (hereafter collectively "Defendants") on behalf of itself and its members for violations of California's Unfair Competition Law.

Except as to the allegations of Plaintiff's experiences, which are based on personal knowledge, all other allegations are based on information and belief and are formed based on an inquiry reasonable under the circumstances.

NATURE OF THE ACTION

1. This action arises out of Defendants' systemic practice of illegally referring injured workers to those of its contracted health care professionals who acquiesce to the deepest discounts and other systemic policy violations.

2. MedRisk's system is nothing like a traditional Preferred Provider Organization ("PPO") where the PPO contracts with health care providers, and the payors let their beneficiaries choose to receive services from any of the health care providers who contract with the PPO, and then the payors pay the claims submitted by those contracted providers. Rather, MedRisk solicits deep discounts of a specified amount from its contracted health care professionals as an inducement for MedRisk to send them more referrals. MedRisk assigns injured workers to the provider of MedRisk's choosing, thus further ensuring it maximizes its revenue by assigning these injured workers to the providers who have acquiesced to the deepest discounts.

3. Under this system, over the past several years, MedRisk has engaged and continues to engage in a uniform and illegal practice of soliciting and receiving improper payments for the referral of healthcare services and managing services provided to injured workers in violation of California Labor Code § 3215, which prohibits offering or accepting any kind of compensation or inducement in exchange for referrals, in both its relationships with its workers' compensation insurers, self-insured employers and third-party administrators and in its relationships with its contracted health care professionals.

4. Similarly, MedRisk's alleged misconduct is in violation of California Labor Code § 3820, which prohibits knowingly soliciting discounts as an inducement for referring patients to obtain workers compensation benefits and knowingly receiving other consideration as compensation for referring patients to obtain medical or medical-legal services.

5. Defendants further exacerbate their unlawful payment scheme by engaging in a systemic practice of failing to comply with requirements that employers and their agents accept electronic claims, acknowledge their receipt electronically upon submission, process and pay those claims expeditiously, provide prompt, clear explanations for any claim contest or denial, and abide by the internal and external billing dispute mechanisms.

6. By this action, Plaintiff seeks injunctive and declaratory relief to remedy Defendants' on-going violations of California's Unfair Competition Law, Cal. Bus. & Prof. Code §§ 17200, *et seq.* ("UCL") based on schemes that MedRisk is illegally referring injured workers to those of its contracted providers who acquiesce to the deepest discounts and other systemic policy violations. Plaintiff's requested relief does not require canceling, amending or altering third party contracts. Moreover, Plaintiff's claim is not barred based on the doctrine of primary jurisdiction or abstention as it does not seek to have this Court assume the administrative functions of the California Department of Worker's Compensation ("DWC") or interfere with the functions of the DWC, and the relief sought does not require this Court to usurp or impinge upon those functions. However, it does require that Defendant cease from the practice of illegally referring patients to providers based on lower rates and pocketing the difference, which affects the ability of Plaintiff's members to do business, is injurious to the public, and is an illegal and unfair business practice. Plaintiff also seeks an order requiring Defendants to comply with all legal requirements regarding electronic billing. Defendants' conduct is continuing and will not be remedied absent the relief sought herein by Plaintiff on behalf of itself and its members under the UCL.

7. As the heart of this action involves systemic policy violations which make extensive participation of individual members unnecessary, Plaintiff has associational standing to pursue this action.

PARTIES

8. On personal knowledge, California Chiropractic Association ("Cal Chiro") is a California corporation with its principal place of business located in Sacramento, California. Cal Chiro is a non-profit membership organization, with approximately 2,200 chiropractor members located throughout the State of California. Cal Chiro's stated mission is to position chiropractors to improve the quality of life of all Californians. In doing so, Cal Chiro has a multi-pronged approach. Cal Chiro seeks to provide its members with services and programs designed to effectively represent chiropractors before state government, communicate to chiropractors the latest clinical and governmental news affecting their practices and patients, offer products and services through partners and others to positively impact patient treatment, and enhance the public's knowledge of benefits of chiropractic treatment. Cal Chiro actively engages in media, legislative, political and regulatory processes to carry out its mission. Additionally, Cal Chiro regularly engages with government and private health plans to advocate for the interests of its members and works to represent members in discussions with numerous companies, including MedRisk and its subsidiary companies, with respect to payment practices such as at issue in this Complaint.

9. Cal Chiro brings this lawsuit in its capacity as an association, and on behalf of its members. As further set forth below, Plaintiff's members have lost, and continue to lose, patients and income, and continue to have patients diverted as a result of MedRisk's illegal conduct as a "middleman" in California's workers' compensation system. Plaintiff does not seek any individual relief greater or different than would benefit its members. Plaintiff has made numerous attempts to resolve this matter pre-litigation, including regulatory and legislative efforts, among other measures. Defendants' conduct has created untenable business conditions for Plaintiff and its members. Defendants' cartel-like conduct is continuing and will not be remedied absent the relief sought herein by Plaintiff on behalf of itself and its members.

10. Defendant MedRisk, LLC is a company organized under the laws of Delaware with its principal place of business located in King of Prussia, Pennsylvania, and is registered to do business in California but has no registered address in California. On information and belief,

MedRisk, LLC is transacting business as an unlicensed workers' compensation provider network broker in and from this State. Moreover, on information and belief, MedRisk, LLC conducts activities in California directly and through various divisions and subsidiaries operating here.

11. Defendant MedRisk Holdco, LLC is a company organized under the laws of Delaware with its principal place of business located in King of Prussia, Pennsylvania, and is registered to do business in California but has no registered address in California. On information and belief, MedRisk Holdco, LLC is transacting business as an unlicensed workers' compensation provider network broker in and from this State.

12. The true names, roles and/or capacities of Defendants named as DOES 1 through 10, inclusive, are currently unknown to Plaintiff and, therefore, are named as Defendants under fictitious names as permitted by the rules of this Court. Plaintiff will identify their true identities and involvement in the wrongdoing at issue if and when they become known, and seek leave of this Court to amend the complaint and serve such fictitiously named Defendants.

13. Plaintiff is informed and believes, and thereon alleges, that DOES 1 through 10 are the partners, agents, owners, shareholders, managers, or employees of MedRisk, LLC, and MedRisk Holdco, LLC at all relevant times.

14. Plaintiff is informed and believes, and thereon alleges, that each and all of the acts and omissions alleged herein was performed by, or is attributable to, MedRisk, LLC, and MedRisk Holdco, LLC, and/or DOES 1 through 10 (collectively "Defendants"), each acting as the agent, employee, alter ego, and/or joint venturer of, or working in concert with, each of the other co-Defendants and was acting within the course and scope of such agency, employment, joint venture, or concerted activity with legal authority to act on the others' behalf. The acts of any and all Defendants were in accordance with, and represent, the official policy of Defendants.

15. Defendants' conduct described herein was undertaken or authorized by Defendants' officers or managing agents, who were responsible for supervision and operating

decisions relating to the conduct at issue in this Complaint. The conduct of these managing agents and individuals was undertaken on behalf of Defendants. Defendants had advance knowledge of the actions and conduct of these individuals, whose actions and conduct were ratified, authorized, and approved by such managing agents. As set forth below, Defendants unjustly and mutually profited as a result of this conduct, in violation of the laws detailed herein. As a result of agreements, either express or implied, to engage in such conduct, Defendants conspired and aided and abetted each other in violating the laws set forth herein. Such conduct is on-going.

16. Plaintiff is informed and believes, and further alleges, that at all relevant times there has existed a unity of interest and ownership between MedRisk, LLC, and MedRisk Holdco, LLC, such that any individuality and separateness between these entities have ceased.

17. MedRisk, LLC is therefore the alter ego of MedRisk Holdco, LLC, which is and at all relevant times has been merely a shell, instrumentality, and conduit through which MedRisk Holdco, LLC carries on business in the State of California.

18. Adherence to the fiction of the separate existence of Defendants MedRisk, LLC, and MedRisk Holdco, LLC as distinct from one another would permit an abuse of the corporate privilege, and would promote injustice by protecting Defendants MedRisk, LLC, and MedRisk Holdco, LLC from liability for the wrongful acts committed by it under its various names.

JURISDICTION AND VENUE

19. This Court has jurisdiction over the parties to this action. Plaintiff is a non-profit membership organization based in California. Defendants transact significant business in California. The court has jurisdiction over this action under Article VI, §10 of the California Constitution and §410.10 of the Code of Civil Procedure. Jurisdiction is also proper under Business & Professions Code § 17200, *et seq*.

20. Jurisdiction over Defendants is also proper because Defendants have purposely availed themselves of the privilege of conducting business activities in California, are registered to conduct business in this State and because they currently maintain systematic and continuous business contacts with this State and/or base a significant amount of their operations here by

managing the treatment services for thousands of injured workers who are residents of this State on behalf of numerous California workers' compensation insurers, self-insured employers and third party administrators that do business with Defendants, and therefore, rendering the exercise of jurisdiction by California courts and the application of California law to the claims of the Plaintiff permissible under traditional notions of fair play and substantial justice.

21. Venue is proper in this County because California Code of Civil Procedure §§395 and 395.5, and case law interpreting those sections, provide that if a foreign business entity fails to designate with the office of the California Secretary of State a principal place of business in California, it is subject to being sued in any county in the State that plaintiff desires. On information and belief, Defendants are foreign business entities, and have failed to designate a principal place of business in California with the office of the Secretary of State as of the date this Complaint was filed. Thus, Defendants have no right to any particular venue and Plaintiff may file this complaint in any county in California. *See Hardin v. San Jose City Lines,* 103 Cal. App. 2d 688, 689 (1951); *see also Easton v. Sup.Ct. (Schneider Bros., Inc.),* 12 Cal. App. 3d 243, 246-247 (1970). Moreover, venue is proper in this County because Defendants transact substantial business in this County, several workers' compensation insurers, self-insured employers and third party administrators that hire Defendants either reside or did business with Defendants in this County, Defendants entered into transactions and received substantial profits from contracts with persons in this County, and because numerous Cal Chiro members are located here.

CAL CHIRO'S STANDING

22. On personal knowledge, Cal Chiro has organizational standing to bring these claims in its own capacity as it has been injured in fact and lost money or property as a result of Defendants' wrongful conduct as described herein, including, *inter alia*, by being forced to divert and devote valuable resources to help members deal with Defendants' illegal, unfair and fraudulent practices, the loss of financial resources in investigating these claims and diversion of staff time to investigate and attempt to resolve such claims, and efforts taken by Cal Chiro to identify, combat and counteract the harm caused by such conduct, consistent with its mission to

do so. Resources that could otherwise have been spent on fulfilling the organization's goals were, and are being, diverted to address the systemic practices alleged herein.

23. Cal Chiro also has associational standing to act on behalf of its members because Cal Chiro members have been harmed by Defendants' conduct (although such members are not in any way required to participate individually to seek the prospective, injunctive and equitable relief requested in this action); the interests Cal Chiro seeks to protect are highly relevant to the organization's purpose as set forth above; and a strong likelihood exists that Cal Chiro's members will be harmed in the future. In addition to the specific redress it seeks for its own injury, Cal Chiro seeks declaratory and injunctive relief on behalf of its members. Both Cal Chiro and its members have been harmed by the wrongful acts and practices of Defendants as set forth in this Complaint. An association that has suffered injury in fact and lost money or property as a result of defendant's wrongful conduct may represent its members as the plaintiff in a UCL action.

24. Further, Plaintiff has associational standing because the individual participation of each member of the Plaintiff association is not *indispensable* to resolution of Plaintiff's claims. Indeed, neither the UCL claims asserted nor the injunctive and declaratory relief requested as set forth herein, require the participation of individual members. Defendants' systemic policy violations make extensive individual participation of Plaintiff's members unnecessary. To be clear, however, the participation of *some* members is not fatal to associational standing, so long as the participation of *each* member is not required. Cal Chiro has standing to pursue the UCL claims on behalf of its members, even if it might need to rely on evidentiary submissions of *some* of its members to establish the UCL violations. Moreover, as Cal Chiro seeks only equitable relief from these UCL violations, both the claims and relief support judicially efficient management. *United Farmers Agents Assn, Inc. v. Farmers Group, Inc.*, 32 Cal. App. 5 478 (2019).

25. Cal Chiro has lost money or property as a result of the practices set forth herein and has expended considerable time and out of pocket expenses, as well as both financial and staff resources, prior to initiation of this action and independently of this action, to help Cal

Chiro's members regarding Defendants' alleged illegal practices, separate and apart from this litigation. These efforts include, but are not limited to, incurring costs and expenses relating to retaining legislative analysists to evaluate the practice of illegal referrals based on discounted rates, incurring travel and meeting expenses to meet with legislative officials to discuss the illegal practice, engaging in communications with members, and expending numerous valuable hours of Cal Chiro's leadership's time, which could have been spent on other projects, in order to manage the complaints received from Cal Chiro members regarding Defendants' alleged violations of state law, which Cal Chiro would have otherwise expended in other ways to advance the mission of Cal Chiro set forth above.

26. Cal Chiro has, during the last several years and prior to this litigation, been required to devote significant resources of its staff and Board members to assist its members in addressing Defendants' improper practices as alleged in this Complaint. Cal Chiro has received and responded to communications from multiple professional chiropractor members who have been pressured to lower prices, been threatened with termination or reductions in referrals, or have actually been terminated or otherwise lost patients and business, all in a manner in contravention with the California laws cited herein. In many cases, patients have been steered away from their preferred chiropractor providers who are members of Cal Chiro during a session of care simply because their clinic is not the lowest cost provider that contracts with MedRisk. MedRisk also has been participating in utilization review (UR) and claims administrator activities without any license or certification, which is in violation of California statutes. The Cal Chiro leadership has thus been forced to expend significant time and resources in investigation of and efforts to redress Defendants' wrongdoing.

27. Cal Chiro has also expended resources in communicating with and educating its members about their rights and obligations with respect to Defendant's illegal activities, as well as communicating concerns regarding Defendants' practices with the Division of Workers' Compensation as the only oversight committee agency in the State of California, the Senate Labor, Public Employment and Retirement Committee, numerous state legislators, and leadership of other healthcare professional associations.

28. In addition, Cal Chiro members have been harmed by these practices, as there are many cases where Cal Chiro members are not able to provide care for California's injured workers at all because the only way to access a patient is to contract with Defendants. Historically, the typical California chiropractor outpatient provider could be expected to have a mix of 10-20% workers compensation patients as a percentage of their overall practice. That has eroded dramatically in the past 15 years following changes in various laws affecting chiropractic access and reimbursement in the workers compensation system. As a consequence, less than 10% of California chiropractors are willing to see injured workers, and Defendants' practices have further reduced many Cal Chiro members' participation to less than 1-3% of their practice. In effect, the reimbursement policies of Defendants have driven most Cal Chiro members out of treating injured workers.

29. Cal Chiro has been forced to expend significant resources in an attempt to combat and counteract Defendants' practices, further establishing its standing to assert such claims on behalf of both itself, and its members. Cal Chiro spent significant resources dealing with complaints relating to disputes with MedRisk. However, Cal Chiro's concerns were not resolved, necessitating this action. Thus, Defendants' illegal conduct has impacted Plaintiff's operating budget, causing it actual economic injury, and Plaintiff has expended funds independently of the litigation to investigate and combat Defendants' misconduct. Defendants' practices have perceptively impaired Plaintiff's ability to service its members and been a drain on the organization's resources, requiring Plaintiff to divert resources to counteract Defendants' illegal practices. Plaintiff undertook the expenditures described herein in response to, and to counteract, the effects of Defendants' alleged misconduct and not in anticipation of litigation.

30. As further alleged in detail below, Plaintiff, who has lost money or property as a result of Defendants' unfair business practice, seeks to prohibit ongoing unlawful acts that threaten future injury to its members and California's injured workers as set forth in this Complaint.

31. Plaintiff reserves the right to expand, limit, modify, or amend these allegations at any time, based upon, *inter alia*, changing circumstances and/or new facts obtained during

discovery.

DEFENDANTS' ILLEGAL REFERRAL SCHEME

32. Employers are required to pay for their employees' medical expenses that result from any workplace injury or illness. Employers generally provide workers compensation coverage for their employees either by purchasing insurance from workers' compensation insurance carriers, or by self-insuring. As a result of major pieces of legislation including, but not limited to, Senate Bill 899 (Stats. 2004, ch. 34), Senate Bill 863 (Stats. 2012, ch. 363) and Senate Bill 542 (Stats. 2015, ch. 542), the employer has significant control over the treatment services received by injured workers, including the injured worker's selection of his or her primary physician.

33. MedRisk has capitalized on this process by systemically offering and providing a preference to those health care professionals who agree to the lowest prices, without regard to their quality of care or other relevant factor, and as a result, retaining greater net compensation from its payor clients. MedRisk solicits deeper discounts from these health care professionals in exchange for more referrals; obtains discounts from health care professionals as an "inducement" or "preference" for referrals; and to the extent it retains the spread created from such discounts, MedRisk receives payments from the payors of workers compensation claims as compensation for making those referrals that increase with the size of the discounts MedRisk negotiates in the form of the spread described above, all in violation of California law.

34. Specifically, MedRisk acts as an illegal, for-profit "middleman" in California's workers' compensation system. MedRisk solicits and receives improper payments for the referral of healthcare services and managing services provided to injured workers in California in a multitude of ways that violate numerous California laws. These laws are specifically designed to protect injured workers, including laws requiring authorization or certification to engage in such conduct in California.

35. MedRisk is known in the industry as a "cost containment" firm. In fact, MedRisk operates as an unlicensed network broker, contracting, on the one hand, with the payors of workers' compensation services, including workers' compensation insurers, self-

insured employers and third party administrators, to handle the scheduling and payment of treatment visits for injured workers, and, on the other hand, with the health care professionals who provide health care services to injured workers at the deeply discounted rates imposed by MedRisk. As set forth below, MedRisk apparently operates in California without any license, certificate of consent or other certification as a California workers' compensation claims administrator, third party administrator, or claims adjustor in violation of numerous California laws.

36. MedRisk operates an illegal referral system whereby MedRisk maximizes the compensation it receives from its payor clients by referring injured workers to those of its contracted health care professionals who acquiesce to the deepest discounts. This system is nothing like a traditional PPO where the PPO contracts with health care providers, and the payors let their beneficiaries choose to receive services from any of the health care providers who contract with the PPO, and then the payors pay the claims submitted by those contracted providers.

37. Rather, MedRisk solicits (or extorts) deep discounts of a specified amount from its contracted health care professionals as an inducement for it to send them more referrals. Similarly, unlike traditional PPO arrangements, injured workers are not simply free to select a health care provider from among the contracted health care professionals. Rather, MedRisk assigns injured workers to the provider of MedRisk's choosing, thus further ensuring it maximizes its revenue by assigning these injured workers to the providers who have acquiesced to the deepest discounts.

38. As a direct result, MedRisk illegally provides a preference to providers in receiving such referrals. The payment MedRisk receives from its workers' compensation payor clients for its management services is tied to the number of referrals MedRisk makes and the size of the discounts MedRisk obtains from its contracted health care professionals who care for injured workers.

39. Further, MedRisk's payor clients do not directly pay health care professionals' claims. Rather, MedRisk pays these claims and pockets whatever difference there is between

what MedRisk is paid by payors and what MedRisk pays these professionals, creating a direct financial incentive to make referrals to the providers who have acquiesced to the deepest discounts.

40. For example, assume MedRisk agrees to provide all the services one of its client's injured workers needs for 10% less than the California Official Medical Fee Schedule ("OMFS") for workers' compensation treatment services; that is, the client agrees to pay MedRisk 90% of the OMFS for workers' compensation treatment services for treatment services needed by its employees and insureds. If MedRisk then pays its contracted chiropractor 50% of the OMFS, MedRisk would retain 40% of the OMFS for its management services – nearly as much as the chiropractor received for the provided chiropractic treatment. Thus, the larger the discount MedRisk obtains from contracted health care professionals, the greater the amount of compensation MedRisk retains from the employer or insurer who ultimately pays for the treatment services provided to injured workers. As such, MedRisk's financial incentive is both clear, and illegal.

41. MedRisk's clients neither have access to MedRisk's provider contracts nor to copies of bills which these healthcare professionals submit to MedRisk for payment. Indeed, MedRisk forbids health care professionals from including the contracted rate on their bills. Thus, MedRisk's clients may likely not know how much of the money these clients have paid that MedRisk is retaining and not passing on.

42. Moreover, MedRisk does not reimburse providers as required or pass on to providers any increases in reimbursements for services provided. For all the treatment services a chiropractor may provide an injured worker in a day, MedRisk generally pays its contracted chiropractors significantly below what chiropractors would be paid under the OMFS for workers' compensation treatment services, which for a typical chiropractor is approximately $135. The OMFS is based on the Medicare Physician Fee Schedule ("PFS"), which is itself maintained by the Centers for Medicare and Medicaid Services ("CMS") to reflect the realistic cost of doing business for those health care professionals who are providing care to Medicare beneficiaries.

43. MedRisk's scheme has allowed it to reduce payments to health care professionals, including chiropractors, below the reasonable costs of providing the chiropractic services needed by injured workers for optimum recovery, while at the same time providing no transparency to its employer clients with respect to MedRisk's contracts with health care professionals or the amounts these healthcare professionals submit to MedRisk for payment.

44. MedRisk is able to sustain this practice because it controls a significant market share of California's workers' compensation health care services in several workers' compensation service lines, including chiropractic service, by virtue of its contracts with the payors of workers' compensation services. Pursuant to these contracts, MedRisk controls the scheduling of the treatment services for injured workers.

45. Generally speaking, chiropractors not contracted with MedRisk have limited access~~,~~ to provide workers' compensation services to injured workers. Chiropractors who acquiesce to MedRisk contracts, with the steepest discounts, receive the vast majority of referrals from MedRisk. MedRisk expresses to chiropractors, the higher the discount they are willing to accept, the greater the number of referrals they will receive. MedRisk handles the referral and initial scheduling of appointments for the vast majority of these injured workers, and otherwise makes it difficult or impossible for the injured workers, their attorney, or their primary treating physicians to schedule appointments themselves. Thus, MedRisk is benefited by steering injured workers who require chiropractic treatment services, directly to those providers who capitulate to its demands.

46. By doing so, MedRisk has also interfered with the choice of employees in selecting a health care professional of their choice and recommended by their physician. In the case where a newly injured patient has been referred to another health care professional by the treating physician rather than by a MedRisk employee, MedRisk may contact the injured worker directly and reschedule them with the health care professional of MedRisk's choosing – the one who has agreed to the deepest discount.

47. MedRisk further exacerbates its unduly low payment rates by failing to comply with many of the laws and regulations that have been enacted in the last several years requiring

that employers and their agents accept electronic claims, acknowledge their receipt electronically upon submission, process and pay those claims expeditiously, provide prompt, clear explanations for any claim contest or denial, and abide by the internal and external billing dispute mechanisms. As a result, chiropractors continue to deal with all the billing and payment issues that have plagued the workers' compensation system prior to the adoption of these laws, including "lost claims" and payment delays.

48. Because of these practices, injured workers find it difficult to access the care they need, health care professionals are forced to bid against each other and are extorted to accept significantly below standard rates to obtain any referrals or opt out and thus are unable to see workers compensation patients as a significant part of their patient mix, and payors pay inflated amounts to MedRisk because they may not be provided key information about how much MedRisk pays the treating health care professionals.

49. Unduly low payment rates also force health care professionals to see more patients in a day, spend less time with each patient, delegate work to less skilled support personnel, defer making capital investments in their practices, and seek employment by hospitals or health systems, lessening the availability of such professionals for direct contact, assessment and treatment. The prospective cap created by MedRisk's programs that requires chiropractors who wish to be preferred providers within the MedRisk network, and thus receive the most referrals, to stay at or below the average utilization rate of all chiropractic practices in California, without regard to the needs of their individual patient populations, also creates significant harm. The gravity of the harms created by Defendants' conduct thus not only affect Plaintiff and its members, but also injured workers. In the short run, Defendants' conduct degrades the quality of medical services injured workers receive; in the long run, it will exacerbate the access issues already encountered by injured workers, driving up the costs of absenteeism and ultimately the medical cost of services rather than acting in what are the injured worker's best interests in the first instance. MedRisk is the primary party that benefits as a result of these transactions, to the detriment of all others who are significantly harmed as a result of such conduct.

50. The participation of *some* of Plaintiff's members is not fatal to associational standing so long as the participation of *each* member is not required. As set forth in this Complaint, Defendants' systemic policy violations make extensive individual participation of Plaintiff's members unnecessary. The prerequisite for associational standing - that the claim not require the participation of individual members - is best seen as focusing on matters of administrative convenience and efficiency. Moreover, as Cal Chiro seeks only equitable and declaratory relief from Defendants' UCL violations, both the claims and relief support judicially efficient management based on associational standing. *United Farmers Agents Assn, Inc. v. Farmers Group, Inc.*, 32 Cal. App. 5 478 (2019). Moreover, Plaintiff's requested relief does not require canceling, amending or altering third party contracts.

51. The individual participation of each member of the Plaintiff association is not indispensable to resolution of Plaintiff's claims. Plaintiff's claims can be established with evidence from MedRisk and documentation from some members, such as a small, but significant sample of Plaintiff's members.

52. Defendants' conduct violates the UCL, as well as the numerous California laws that prohibit Defendants from engaging in illegal payment schemes, prohibiting referral systems for workers' compensation treatment services that are directly tied to financial incentives, prohibiting Defendants from operating without the required authorizations as a physician network service provider, claims administrator or claims adjustor, and otherwise interfering with the health care services being provided to injured workers by their chiropractors. Such conduct is in violation of numerous laws as set forth in detail below.

53. California Labor Code § 139.32(c) provides, in relevant part, that "it is unlawful for an interested party other than a claims administrator or a network service provider to refer a person for services provided by another entity, or to use services provided by another entity, if the other entity will be paid for those services . . . and the interested party has a financial interest in the other entity."

54. MedRisk is not a "physician network services provider" as that term is defined under the Labor Code. To the extent MedRisk is conducting business outside of an MPN as to

which they are authorized "physician network service providers," it does so in violation of Labor Code § 139.32(c).

55. MedRisk is not a claims administrator under the Labor Code. The entity that administers workers' compensation coverage for an employer is known as the "Claims Administrator." Specifically, the term "Claims Administrator" means a self-administered insurer providing security for the payment of compensation, a self-administered self-insured employer, or a third-party administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority. 8 C.C.R. § 9785(a)(3). For purposes of payment requirements, the term "Claims Administrator" means the person or entity responsible for the payment of compensation for any of the following: a self-administered insurer providing security for the payment of compensation, a self-administered self-insured employer, a group self-insurer, an insured employer, the director of the Department of Industrial Relations as administrator for the Uninsured Employers Benefits Trust Fund (UEBTF) and for the Subsequent Injuries Benefit Trust Fund (SIBTF), a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, group self-insurer, or joint powers authority, and the California Insurance Guarantee Association (CIGA). 8 C.C.R. § 1(i).

56. Pursuant to Labor Code § 3702.1, no person, firm, or corporation can act as a Claims Administrator and contract to administer claims of self-insured employers in California unless they are themselves an insurer admitted to transact workers' compensation insurance in California, or they have a certificate of consent to administer self-insured employers' workers' compensation claims. A separate certificate is required for each adjusting location operated by the Claims Administrator. And Claims Administrators for self-insured employers must estimate, in good faith and with the exercise of a reasonable degree of care, the total accrued liability of the employer for the payment of compensation for the employer's annual report to the director. No available public records Plaintiff has been able to locate indicate that MedRisk is directly licensed or otherwise authorized to operate as a Claims Administrator in California.

57. As described above, MedRisk has a financial interest in the payor of the services as defined by Labor Code § 139.32(a)(1) in that MedRisk's compensation is based in whole or

in part on the volume or value of the services provided as a result of referrals. MedRisk has a financial interest in each of these contracted health care professionals, and they are a representative or agent of their employer, insurer and claims administrator clients based on the contractual relationships described herein, and because they are being paid pursuant to those contractual relationships.

58. MedRisk does not generally solicit rate offers from health care professionals. Rather, MedRisk dictates the rates it will pay in exchange for referring patients to these professionals, and determines referrals based on the pricing that providers will accept. Nothing in the approved OFMS schedule provides for the use of this type of tiered pricing process. MedRisk's own emails to Plaintiff's members confirm that MedRisk conditions fee increases on the number of referrals and that fee increases adversely affect the number of referrals that Plaintiff's members can receive.

59. MedRisk's representatives routinely communicate the contrasting rates imposed on various competing health care professionals in the same geographic market to other professionals in an effort to convince them to take a drastically lower payment rate in exchange for a preference in terms of a specified increase in the number of referrals they will receive. It has been MedRisk's practice to state the number of referrals that were recently made in a particular geographic area, how few went to a particular chiropractor because of the rate they charged, how many went to competitors in the area who accepted lower rates, and how many more would go to the chiropractor if they agreed to reduce their rates by being able to move up higher on the map of providers. Such statements make clear to chiropractors who do not accede to the deepest discounts MedRisk demands but remain contracted at higher rates that they will receive referrals only when MedRisk cannot refer the injured worker to a practice that has contracted with it at a lower rate in the same geographic area.

60. Such claims also establish that MedRisk is representing its networks are significantly larger than they actually are, since only a small number of referrals, by their own admission, are sent to chiropractors who bill at highest rates. Defendants thus are promoting the existence of a "phantom network," since while they claim they have thousands of contracted

chiropractors in their network, by referring patients primarily to providers who bill at the lowest rates, in fact their network is significantly smaller and narrower. Defendants have used that sort of tiering rating system to extort chiropractors to accept ever lower rates. Being that MedRisk is one of the largest players in this industry and may be required by some companies to be used in order to get any referral business at all, chiropractors have few options if they wish to treat patients with workers compensation-related injuries. Having successfully used this strategy over the last several years, Defendants have been able to, and continue to, skew the entire payment range provided to chiropractors to be significantly below the OFMS rates, claiming such rates are in effect for the indefinite future absent separate agreement. This skewed system impacts the rates of both contracted and non-contracted chiropractors.

61. Pursuant to the OMFS, a chiropractor would typically receive approximately $135 for all the treatment services a chiropractor may provide an injured worker in a day.

62. The rates MedRisk pays chiropractors are significantly below the OMFS rates; MedRisk rates have not increased despite the increases mandated for these services by the OMFS over the last several years as set forth herein. The OMFS rates for chiropractic services were increased again on January 1, 2018; MedRisk so far does not appear to have passed on any of that increase to its contracted chiropractors; if anything, they have tried to get chiropractors to agree to rates as low as half that amount in exchange for increased referrals despite these increases in the OMFS rates in recent years – meaning that Defendants have been further profiting despite the directive to utilize higher payment schedules.

63. Based on statutes endowing employers with near total control of medical care, injured workers rarely refer themselves to chiropractors, nor are they generally referred by their treating physicians; the vast majority of referrals are controlled and made directly by MedRisk or by many adjustors who have been directed to primarily if not exclusively refer patients to MedRisk facilities. Injured workers searching for a convenient chiropractor cannot make an appointment at that practice directly. Rather, MedRisk hijacks the providers' addresses as MedRisk's own, and patients must call the MedRisk phone number listed in the directory, at which point they will be referred to a chiropractor selected by the MedRisk staff. Thus, the

provider directory is simply a method to steer patients to MedRisk's cheapest providers to the benefit of MedRisk. Even though injured workers have the right to choose a new primary treating physician after 30 days if they are dissatisfied with the physician assigned by their employer, MedRisk misleads injured workers into believing they have no such rights when it comes to their chiropractors.

64. Because MedRisk directs its contracted providers to send their bills to MedRisk and not to the ultimate workers' compensation payor insurer or self-insured employer, and MedRisk itself bills its workers compensation payor clients for the services contracted health care professionals provide to injured workers, MedRisk is able to hide from its payor clients the amount of the spread it is able to retain between what these clients pay MedRisk and what MedRisk pays its contracted health care professionals.

65. By dictating the price of services to be charged by competing health care professionals for the provision of treatment services to injured workers as an agent of the competing purchasers of those services, MedRisk is able to set both the rates multiple health care professionals receive and, separately and at a much higher price, the rates multiple workers' compensation payers must pay for their services. In so doing, Defendants' conduct constitutes acts of unfair competition as set forth herein.

66. In sum, MedRisk is paid by workers' compensation payors, at least in part, based on the number of referrals it makes and the size of the discount it has obtained from the health care providers it has contracted with to provide treatment services to injured workers. The larger the discount it has negotiated, the larger the amount it retains from the employer or insurer who ultimately pays for the services provided to injured workers, with MedRisk keeping the "spread" between the contracted rates between MedRisk and the payor on the one hand, and MedRisk and the health care professional on the other. Because MedRisk is paid more when it refers injured workers to specific contracted network providers based on this spread, the amount it is paid increases with the size of the discounts it has negotiated. MedRisk thus has a "financial interest" in its network providers, as defined by Labor Code § 139.32(a)(1) that is tied to the illegal referrals described herein.

67. Further, MedRisk's conduct violates Labor Code § 139.32(d) which states that it is unlawful for an interested party to enter into an arrangement or scheme that the interested party knows, or should know, has a purpose of ensuring referrals by the interested party to a particular entity that, if the interested party directly made referrals to that other entity, would be in violation of this section; and that it is unlawful for an interested party to offer, deliver, receive, or accept any rebate, refund, commission, preference, patronage, dividend, discount, or other consideration whether in the form of money or otherwise, as compensation or inducement to refer a person for services.

68. As described above, MedRisk offers and provides a preference to those chiropractic health care professionals who agree to the lowest price, without regard to their quality of care or other relevant factor, and as a result retains greater net compensation from its payor clients. MedRisk solicits deeper discounts from these health care professionals in exchange for more referrals, obtains discounts from health care professionals as an "inducement" or "preference" for referrals, and to the extent it retains the spread created from such discounts, MedRisk receives payments from the payors of workers compensation claims as compensation for making those referrals that increase with the size of the discounts MedRisk negotiates in the form of the spread described above, all in violation of Labor Code § 139.32(d).

69. Defendants' conduct also violates Labor Code § 3215, which provides that "Except as otherwise permitted by law, any person acting individually or through his or her employees or agents, who offers, delivers, receives, or accepts any rebate, refund, commission, preference, patronage, dividend, discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring clients or patients to perform or obtain services or benefits pursuant to this division, is guilty of a crime."

70. MedRisk violates Labor Code § 3215 in both its relationships with its workers' compensation insurers, self-insured employers and third-party administrators and in its relationships with its contracted health care professionals. From its payor clients, MedRisk "… receives … other consideration … as compensation ... for referring … patients to …obtain services or benefits pursuant to this division …." in the form of the spread it is able to retain, in

violation of Labor Code § 3215. To its contracted health care professionals, MedRisk "receives, [or] delivers … [a] preference, discount or other consideration ... as … inducement for referring clients or patients to … obtain services or benefits pursuant to this division ….", also in violation of Labor Code § 3215.

71. Defendants' alleged misconduct also violates Labor Code § 3820, which makes it unlawful for any person who submits a workers' compensation claim to: (a) knowingly solicit, receive, offer, pay or accept any rebate, referral, commission, preference, discount or other consideration, monetary or not, as compensation or inducement for soliciting or referring clients or patients to obtain workers' compensation benefits; (b) knowingly operate or participate in a service that, for profit, refers or recommends clients or patients to obtain medical or medical-legal services; or (c) knowingly assist or conspire with any person who engages in any of the above.

72. As alleged above, MedRisk demands deep discounts from health care professionals as an inducement for the increased referral of injured workers for health care services in specific geographic areas. MedRisk is paid based on the number of referrals and the size of the discount it negotiates. Thus, MedRisk "knowingly solicits … discount[s] … as … inducement for referring patients to … obtain [workers compensation] benefits" and "knowingly … receives … other consideration … as compensation … for … referring patients to obtain medical or medical-legal services", in violation of Labor Code § 3820(b)(3).

73. In addition, as MedRisk operates as a for profit referral service, it is also "operat[ing] … a service that, for profit, refers … patients to obtain medical … services", in violation of Labor Code § 3820(b)(4).

74. Based on the foregoing, Defendants are acting as unlicensed claims administrators and adjusters in managing the provision of chiropractic services and paying the claims submitted by chiropractors for therapy provided to injured workers on behalf of self-insured employers.

75. Unless the employee has pre-designated a personal physician, the employer may select a treating physician during the first 30 days after a workplace injury is reported. After 30

days from the date the injury is reported, the employee may be treated by a physician or facility of his or her choice within a reasonable geographic area, unless the employer has established an MPN. An MPN is a network of providers, including physicians and other health care professionals, created to provide medical treatment to injured employees. MPNs may be created by self-insured employers, workers' compensation insurers or entities providing physician network services. When the employer has established an MPN, the employer or its representative arranges the initial medical evaluation and treatment on behalf of the employee. Unless exempted by law or the employer, all medical care for injured employees whose employer has an approved MPN will be handled and provided through the MPN pursuant to Labor Code § 4616(a). The MPN determines which locations are approved for physicians to provide treatment under the MPN. 8 C.C.R. § 9767.3(4). Approved locations must be listed in an MPN's provider directory.

76. Except for an employer who has established a MPN or an employer whose insurer has established an MPN, every employer is required to advise employees in writing of their right to: (1) Request a change of treating physician (one time only) if the original treating physician is selected by the employer (Labor Code § 4601); and (2) Be treated by a physician of his or her own choice after 30 days from reporting an injury. 8 C.C.R. § 9782.

77. An employee who is within an MPN may change personal physicians as often as he or she wants after the initial medical evaluation but may only select from those physicians who are members of the MPN.

78. An "entity that provides physician network services," as referenced in Labor Code § 4616(a), means a legal entity employing or contracting with physicians and other medical providers or contracting with physician networks to deliver medical treatment to injured workers on behalf of one or more insurers, self-insured employers, the Uninsured Employers Benefits Trust Fund, the California Insurance Guaranty Association, or the Self-Insurers Security Fund, and that meet the requirements of Labor Code §§ 4616, *et seq*., and corresponding regulations, including 8 C.C.R. § 9767.1(a)(7). It may include, but is not limited to, Claims Administrators.

79. Unlicensed network brokers such as MedRisk may become MPNs, but an MPN cannot act as a Claims Administrator unless it is also a licensed workers' compensation insurer or third-party administrator. MedRisk does not fall into either category.

80. A complete, up-to-date list of MPNs is available at: www.dir.ca.gov/dwc/mpn/DWC_MPN_Main.html. MedRisk is not separately listed as an authorized MPN. It is listed as a provider in the MPNs.

81. Chiropractors do not have any reasonable way of knowing whether an injured worker is being referred within or outside of an MPN owned by MedRisk.

82. MedRisk is not licensed as an insurance company in California, nor as a third-party administrator.

83. On information and belief, MedRisk does not appear to have a "certificate of consent" to administer self-insured employers' workers' compensation claims.

84. On information and belief, MedRisk is not an "entity that provides physician network services" as that term is defined under California law as to the chiropractor or other health care professionals with which it contracts, as MedRisk does not directly own an approved MPN.

85. MedRisk does not appear to be certified as workers' compensation claims adjusters or medical-only claims adjusters.

86. MedRisk is not licensed as a physician, chiropractor or other health care provider.

87. Defendants' conduct in managing the provision of chiropractic services and paying the claims submitted by chiropractors for therapy provided to injured workers on behalf of self-insured employers also violates Labor Code § 3702.1, which requires that only an insurer authorized to transact workers' compensation insurance in California, or a third party administrator with a certificate of consent to administer self-insured employers' workers' compensation claims, can act as a Claims Administrator for self-insured employers.

88. Defendants' conduct also violates Insurance Code § 11761, which requires workers' compensation insurers, self-insured employers and third-party administrators to certify

that everyone they contract with to review, adjust or pay workers compensation medical bills is properly trained as a claims adjustor or medical-only claims adjustor. While MedRisk pays the medical claims of the health care professionals to whom it refers patients, and thus is acting as a "medical-only claims adjustor," MedRisk is not publicly listed as being certified to perform this function. Thus, even assuming MedRisk is even authorized to perform the services of a licensed third-party administrator, which Plaintiff contests, MedRisk's claims adjusting activities violate Insurance Code § 11761.

89. In not maintaining the required licenses, authorizations or certificates of consent, Defendants are violating numerous California laws as set forth in this Complaint, including, *inter alia*, Business and Professions Code §§ 2400, 2630 and 2694, Labor Code § 3702.1 and Insurance Code § 11761.

90. Defendants' conduct also violates Labor Code § 4610(g) which requires that utilization review programs be accredited by the Utilization Review Accreditation Commission ("URAC') for all employers providing workers compensation benefits in California. Under Labor Code § 4610(g)(M), a request for authorization, including its supporting documentation, shall not be altered or amended by any entity other than the requesting physician or provider prior to the submission of the request to the claims administrator. MedRisk is not one of the 24 California URAC accredited programs.

91. By illegally referring patients as alleged herein, MedRisk is violating Labor Code § 4610(g) by inserting itself into patients' plans of care and mandating changes to those care plans by altering or amending who can provide the patient care. In violation of Labor Code 4610(g), MedRisk employs a referral process for its profit (moving a patient from one provider to another when the discount provided by the second is greater than that contracted by the first). It does so within a process that is supposed to be accredited by URAC but is not so accredited or listed as part of an accredited process. To the extent that moving patients without their consent is a function of utilization review, unless MedRisk operates under one of the 24 California URAC accredited programs listed by URAC, the conduct is illegal, and Defendants are not permitted to do so. By way of analogy, MedRisk is not only driving 100 mph on the freeway, it

is doing so without a driver's license, and apparently without having participated in driver's ed. MedRisk is not entitled to flout the law.

92. All of the foregoing are predicate violations of the UCL for the purpose of determining whether Defendants engaged in unlawful business practices. The Court would not be setting or changing DWC policy; it would be presiding over an unfair competition action where it will be determined whether Defendants' unfair scheme has violated one or more California laws.

BILLING AND PAYMENT VIOLATIONS

93. MedRisk further exacerbates its unduly low payment rates by failing to comply with many of the laws and regulations that have been enacted in the last several years requiring that employers and their agents accept electronic claims, acknowledge their receipt electronically upon submission, process and pay those claims expeditiously, provide prompt, clear explanations for any claim contest or denial, and abide by the internal and external billing dispute mechanisms. As a result, chiropractors continue to deal with all the billing and payment issues that have plagued the workers' compensation system prior to the adoption of these laws, including "lost claims" and payment delays.

94. Defendants' conduct in submitting bills for and collecting payments for chiropractic services also violates Business and Professions Code §§ 2400, 2630 and 2694, as Defendants are not licensed to practice as chiropractors.

95. Defendants' claims handling and payment activities further violate the entire system governing the electronic handling and payment of bills for workers' compensation medical treatment. Defendants' failure to accept electronic claims, acknowledge their receipt electronically upon submission, process and pay those claims expeditiously at no additional cost to the chiropractors, provide prompt, clear explanations for any claim contest or denial, and abide by the legally mandated internal and external billing dispute mechanisms violates Labor Code §§ 4603.2, 4603.4 and 4603.6 and their implementing regulations, 8 C.C.R. §§ 9792.5.1, *et seq*.

96. Under California Labor Code § 4603.4, since 2012 if not earlier, employers and

their agents must accept electronic claims for the payment of medical services provided to injured workers. In addition, payment of any uncontested amount for medical treatment provided or prescribed by the treating physician, whether selected by the employee or designated by the employer, must be made within 15 working days after electronic receipt of an itemized electronic bill for services and at no additional cost to the payee. In addition, the payor must provide an explanation of review, which explains the payment, as well as any portion of the payment which is contested or denied.

97. Under California Labor Code § 4603.2, the explanation of review must include all the following:

a. A statement of the items or procedures billed and the amounts requested by the provider to be paid.

b. The amount paid.

c. The basis for any adjustment, change, or denial of the item or procedure billed.

d. The additional information required to make a decision for an incomplete itemization.

e. If a denial of payment is for some reason other than a fee dispute, the reason for the denial.

f. Information on whom to contact on behalf of the employer if a dispute arises over the payment of the billing. The explanation of review shall inform the medical provider of the time limit to raise any objection regarding the items or procedures paid or disputed and how to obtain an independent review of the medical bill pursuant to Section 4603.6.

98. California Labor Code §§ 4603.2 and 4603.6 establish extensive procedures governing the handling of disputes over workers' compensation billing and payment. Among other things, these laws provide a significant penalty on late payments. A late payment must be paid at 15% more than the OFMS then in effect, together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the initial bill. Labor Code §§ 4603.2 (b)(1)(C)(2) and 4603.4 (d).

99. The regulations implementing these statutes, 8 C.C.R. §§ 9792.5.1, *et seq.*, and

the California Division of Workers' Compensation Medical Billing and Payment Guide and the California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide adopted by those regulations, further require that the claims administrator send electronic claims acknowledgments and remittance advice (explanations of review) and pay electronic claims within 15 days.

100. MedRisk does not comply with these laws, does not pay on time, and does not pay interest, thus significantly increasing the administrative burden on chiropractors, significantly delaying and reducing the payments they would otherwise receive and eliminating any ability for Defendants' employer clients from auditing MedRisk's actual payment activities.

CLASS ALLEGATIONS AND COMPLIANCE WITH CCP § 382

101. As an association, Plaintiff can bring a representative action on behalf of its members and represent its members under the UCL where, as here, the association itself has suffered injury in fact and lost money or property.

102. To the extent that Plaintiff, an association, must bring this action as a class action and/or satisfy the requirements of California Code of Civil Procedure § 382, those requirements are satisfied.

103. The proposed Class which Plaintiff seeks to represent is composed of and defined as follows:

> All members of California Chiropractic Association who are located in the State of California that provide chiropractic treatment services to injured workers in California, during the four (4) year period preceding the filing of this Complaint through the date of final judgment in this action (the "Class").

104. Excluded from the Class are Defendants; their corporate parents, subsidiaries, affiliates, and any entity in which Defendants have a controlling interest; any of their officers, directors, employees, or agents; the legal representatives, successors or assigns of any such excluded persons or entities; and the judicial officers to whom this matter is assigned as well as their court staff. Plaintiff reserves the right to expand, limit, modify, or amend this class definition, including the addition of one or more subclasses, in connection with its motion for

class certification, or at any other time, based upon, *inter alia*, changing circumstances and/or new facts obtained during discovery.

105. This action has been brought and may properly be maintained pursuant to the provisions of California Code of Civil Procedure § 382 because there is a well-defined community of interest in the litigation, the proposed Class is easily ascertainable and there are substantial benefits from certification that render proceeding as a class action superior to the alternatives..

106. Numerosity: The members of the Class are so numerous that joinder of all members for purposes of pursuing this action is unfeasible and impractical. Plaintiff estimates that there are as many 2,200 chiropractor members located throughout the State of California in the Class. Moreover, Plaintiff alleges that members of the Class, their identities, and their locations can be ascertained though appropriate discovery and records of Plaintiff.

107. Common Questions Predominate: Common questions of law and fact exist as to all members of the Class and predominate over any questions which affect individual members of the Class. These common legal and factual questions include, but are not limited to, the following:

a. Whether, during the Class Period, Defendants have engaged and continue to engage in a uniform, systemic and illegal practice of soliciting and receiving improper payments for the referral of healthcare services and managing services provided to injured workers in violation of Labor Code § 3215;

b. Whether, during the Class Period, Defendants have engaged and continue to engage in a uniform, systemic and illegal conduct in violation of Labor Code § 3820, which prohibits knowingly soliciting discounts as an inducement for referring patients to obtain workers compensation benefits and knowingly receiving other consideration as compensation for referring patients to obtain medical or medical-legal services.

c. Whether Defendants' conduct is an "unlawful" act or practice within the meaning of California Business & Professions Code §17200;

d. Whether Defendants' conduct is a "deceptive" act or practice within the meaning

of California Business & Professions Code §17200;

e. Whether Defendants' conduct is an "unfair" act or practice within the meaning of California Business & Professions Code §17200; and

f. Whether Plaintiff and its members are entitled to injunctive relief to enjoin or restrain such unlawful practices by Defendants.

108. Typicality: Plaintiff's claims are typical of the claims of the members of the Class. Plaintiff's members have sustained injuries and damages arising out of Defendants' common course of conduct in violation of law as complained of herein. Plaintiff is advancing the same claims and legal theories on behalf of itself and all members of the Class. Accordingly, Plaintiff has no interests antagonistic to the interests of any other member of the Class.

109. Adequacy: Plaintiff, as a representative party, will fairly and adequately protect the interests of the Class by vigorously pursuing this lawsuit through attorneys who are skilled and experienced in handling class action matters of this type.

110. This action is maintainable as a class action because Defendants have acted or refused to act on grounds generally applicable to the Class as a whole and Plaintiff seeks, *inter alia*, equitable remedies with respect to the Class as a whole. As such, the systematic policies and practices of Defendants make final injunctive relief and/or declaratory relief with respect to the Class as a whole appropriate.

111. This action is maintainable as a class action because the common questions of law and fact predominate over any questions affecting individual members of the Class. Moreover, a class action is clearly superior to alternative methods for the fair and efficient adjudication of the controversy. Class treatment will permit a large number of similarly situated persons or entities to prosecute the claims in a single forum simultaneously, efficiently, and without the unnecessary duplication of evidence, effort, and expense that numerous individual actions would produce.

112. This case will be manageable as a class action. Plaintiff knows of no difficulty to be encountered in the prosecution of this action that would preclude its maintenance as a class action. Further, because Plaintiff's members are ascertainable from Plaintiff's records, there is a

well-defined community of interest among Plaintiff's members.

FIRST CLAIM FOR RELIEF

Violation of the Unfair Competition Law
(Cal. Bus. & Prof. Code §§ 17200, *et seq*.)
Unlawful, Unfair, and Deceptive or Fraudulent Business Acts and Practices

113. Plaintiff incorporates by reference each of the preceding paragraphs as though fully set forth herein.

114. Plaintiff brings this claim on its own behalf and on behalf of its members, as set forth above.

115. As a result of Defendants' acts and practices in violation of Business and Professions Code §§ 17200, *et seq*. ("UCL"), Plaintiff has suffered injury in fact and lost money or property as set forth above. In addition, as a result of the acts alleged herein, Plaintiff's members have been injured in fact and lost money or property as a result of Defendants' acts and practices, as they have lost and continue to lose patients and continue to have patients diverted to providers who have been forced to accept unreasonably low rates from MedRisk, in violation of law, and through the efforts they have had to expend combatting Defendants' conduct, and will continue to do so.

116. The UCL defines unfair competition to include any unlawful, unfair or fraudulent or deceptive business act or practice. Defendants have committed acts of unfair competition proscribed by Business and Professions Code §§ 17200, *et seq*., including the acts and practices alleged herein.

117. The UCL imposes strict liability. Plaintiff need not prove that Defendants intentionally or negligently engaged in unlawful, unfair, or fraudulent business practices – only that such practices occurred.

118. A business practice is "unlawful" under the UCL if it is forbidden by law, including state laws or regulations, and the violation of any law may serve as the predicate for a violation of the "unlawful" prong of the UCL. Defendants' conduct is unlawful under numerous California laws and regulations, as set forth herein.

119. The acts and practices of Defendants as described above constitute "unfair" business acts and practices. Plaintiff and its members have also suffered injury in fact and a loss of money or property as a result of Defendants' unfair business acts and practices as set forth in detail above and will continue to do so.

120. Defendants' conduct does not benefit consumers or competition. Indeed, the harm to consumers who are forced to utilize such services and to competition in the form of health care professionals who are either forced to accept unreasonable payments or forego providing such services altogether to a significant number of consumers is significant, for the reasons set forth above.

121. Plaintiff, its members and the affected public could not have reasonably avoided the injury each of them suffered, which injury is substantial.

122. The gravity of the consequences of Defendants' conduct as described above outweighs the justification, motive or reason therefor, is immoral, unethical and unscrupulous, and offends established public policy that is tethered to legislatively declared policies as set forth in the laws detailed above, or is substantially injurious to the public, for the reasons set forth above.

123. The gravity of the harm attributable to those practices is substantial. Discounts of the magnitude MedRisk demands can only be accommodated by reducing the quality of the medical treatments that can be offered. With respect to chiropractic services, that means patients must receive less direct supervision, and more services must be delegated to supportive personnel. For example, the blanket, prospective cap created by MedRisk's programs that requires chiropractors who wish to be "preferred providers" within the MedRisk network and thus receive the most referrals to stay at or below the average cost for chiropractic practices in California, without regard to the needs of their individual patient populations, adversely impacts injured workers and their right to necessary medical care, and imposes the greatest harm on the most severely injured patients with the greatest medical need.

124. The acts and practices of Defendants as described above also constitute "fraudulent" or "deceptive" business practices as that term is used in Business & Professions

Code §§ 17200, *et seq.* Plaintiff and its members have suffered injury in fact and a loss of money or property as a result of Defendants' deceptive or fraudulent business acts and practices as set forth in detail above, and will continue to do so.

125. Defendants' obfuscated contracting and patient referral scheme is also likely to deceive both injured workers and workers' compensation payors, as set forth in detail above, into believing they are receiving services and making payments consistent with what the law permits, when in fact they are engaged in a uniform and illegal practice, and that MedRisk's chiropractor "provider network" is significantly larger than it actually is based on the tiered pricing MedRisk uses to narrow its network in making chiropractic patient referrals.

126. As a result of Defendants' scheme, Defendants' clients may have no idea of the magnitude of the discounts Defendants offer or impose, or how little Defendants are actually paying for the treatment services provided to injured workers and are reasonably likely to be misled into believing that the treating providers are receiving fair compensation and that these clients' injured employees are receiving optimal treatment for their injuries. They are also likely unaware of the material fact that Defendants are illegally demanding unreasonably large discounts as an inducement for the referral of these patients and misled into believing Defendants can lawfully conduct business in this State and have the required authorizations to do so, when that may well not be the case.

127. Defendants' conduct and omissions of fact as set forth above were material and thus presumed to be a substantial factor in decisions to utilize Defendants' services, with the result that injured workers were forced to receive services from underpaid chiropractors through a system that does not properly operate in this.

128. Defendants' acts of unfair competition as set forth above present a continuing threat and will persist and continue to do so unless and until this Court issues appropriate injunctive and declaratory relief. In addition, Plaintiff may be entitled to equitable relief according to proof at time of trial. Plaintiff also seeks attorneys' fees and costs pursuant to, *inter alia*, C.C.P. § 1021.5.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff, individually and on behalf of its members as set forth above, prays for relief as follows to the extent permitted by law:

1. Injunctive and declaratory relief;

2. Other equitable relief;

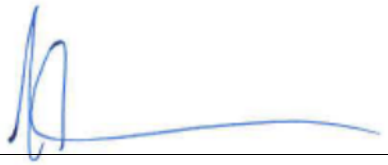
3. Attorneys' fees and costs pursuant to, *inter alia,* C.C.P. § 1021.5; and

4. Such other and further relief as Plaintiff may request and the Court may deem appropriate.

Dated: June 19, 2020

Respectfully submitted,

POMERANTZ LLP



By: _____
Jordan L. Lurie
Ari Y. Basser

Dated: June 19, 2020

Respectfully submitted,

LAW OFFICES OF ZEV B. ZYSMAN
A PROFESSIONAL CORPORATION

By: /s/ Zev B. Zysman
Zev B. Zysman

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Attorneys for Plaintiff

SUPERIOR COURT FOR THE STATE OF CALIFORNIA

FOR THE COUNTY OF ALAMEDA

CALIFORNIA CHIROPRACTIC ASSOCIATION, on behalf of itself and its members,

Plaintiff,

vs.

MEDRISK, LLC; MEDRISK HOLDCO, LLC; and DOES 1 through 10, inclusive,

Defendants.

Case No. RG19045051

[ASSIGNED FOR ALL PURPOSES TO THE HON. JUDGE BRAD SELIGMAN]

PLAINTIFF'S PROOF OF SERVICE OF FIRST AMENDED COMPLAINT

Date Action Filed: November 27, 2019
Trial Date: Not yet set

PROOF OF SERVICE

I am employed in the State of California, County of Los Angeles. I am over the age of 18 and not a party to the within suit; my business address is 1100 Glendon Avenue, 15th Floor, Los Angeles, California 90024.

On **June 19, 2020**, I served the document described as:

PLAINTIFF'S PROOF OF SERVICE OF FIRST AMENDED COMPLAINT

on the interested parties in this action by sending [ ] the original [or] [✓] a true copy thereof [✓] to interested parties as follows [or] [ ] as stated on the attached service list:

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[ ] **BY MAIL (ENCLOSED IN A SEALED ENVELOPE):** I deposited the envelope(s) for mailing in the ordinary course of business at Los Angeles, California. I am "readily familiar" with this firm's practice of collection and processing correspondence for mailing. Under that practice, sealed envelopes are deposited with the U.S. Postal Service that same day in the ordinary course of business with postage thereon fully prepaid at Los Angeles, California.

[✓] **BY E-MAIL:** I hereby certify that this document was served from Los Angeles, California, by e-mail delivery on the parties listed herein at their most recent known e-mail address or e-mail of record in this action.

[ ] **BY FAX:** I hereby certify that this document was served from Los Angeles, California, by facsimile delivery on the parties listed herein at their most recent fax number of record in this action.

[ ] **BY PERSONAL SERVICE:** I delivered the document, enclosed in a sealed envelope, by hand to the counsel for Defendant.

[ ] **BY OVERNIGHT DELIVERY:** I am "readily familiar" with this firm's practice of collection and processing correspondence for overnight delivery. Under that practice, overnight packages are enclosed in a sealed envelope with a packing slip attached thereto fully prepaid. The packages are picked up by the carrier at our offices or delivered by our office to a designated collection site.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on **June 19, 2020,** at Los Angeles, California.

Ari Y. Basser
Type/Print Name

Signature