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United States District Court
Central District of California

MALIBU BEHAVIORAL HEALTH SERVICES INC.,

Plaintiff,

v.

MAGELLAN HEALTHCARE, INC., et al.,

Defendants.

CASE NO. 2:20-cv-01731-ODW (PVCx)

ORDER GRANTING IN PART AND DENYING IN PART MOTION TO DISMISS FIRST AMENDED COMPLAINT [38]

I. INTRODUCTION

This action arises from a medical insurance payment dispute between a medical service provider and an insurer. Plaintiff Malibu Behavioral Health Services, Inc., d/b/a South California Road to Recovery ("Malibu") brings a First Amended Complaint ("FAC") against Defendant AmeriHealth Insurance Company of New Jersey ("AmeriHealth") and AmeriHealth's agent, Defendant Magellan Healthcare, Inc. ("Magellan"; together with AmeriHealth, "Defendants"), seeking $394,985 for unpaid medical services provided to a patient, LK. (*See generally* FAC, ECF No. 31.)

Now before the Court is AmeriHealth's Motion to Dismiss the FAC.[1] (Mot. to Dismiss ("Motion" or "Mot."), ECF No. 38.) The matter is fully briefed. (*See* Mot.; Opp'n to Mot. ("Opp'n"), ECF No. 41; Reply ISO Mot. ("Reply"), ECF No. 42.) For the following reasons, the Motion is **GRANTED in part** and **DENIED in part**.[2]

II. BACKGROUND

Malibu provides monitored, residential, detoxification services with medication assisted treatment. (FAC ¶ 9.) From June 2, 2016, to December 31, 2016, Malibu provided a patient, LK, with "covered treatment . . . for mental health and substance use disorder." (*Id.* ¶¶ 2, 38.) At the time, LK was insured by AmeriHealth under its New Jersey POS Plus policy (the "Policy"), which provides coverage for out-of-network services such as those provided to LK by Malibu. (*Id.* ¶¶ 2, 33; *see* Decl. of Charles Kiehl Cauthorn Ex. A ("Policy"), ECF No. 38-1.)[3] And AmeriHealth's agent, "Magellan[,] had exclusive control over benefits decisions, utilization management and claims handling related to LK's treatment at Malibu." (FAC ¶¶ 12–13.)

Malibu alleges that on January 6, 2016, prior to admitting LK as a patient, it contacted AmeriHealth to conduct a Verification of Benefits ("VOB") call. (*Id.* ¶ 39.) Malibu alleges that all parties understood the term "usual, customary and reasonable rate" ("UCR") to mean 100% of the fully billed amounts charged by Malibu for its services, and that "AmeriHealth's agent promised and informed Malibu that it would be paid for behavioral health services at 90% of UCR (90% of billed charges) until

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[1] Magellan filed its Answer to the FAC on May 29, 2020. (Magellan's Answer, ECF No. 36.)

[2] After carefully considering the papers filed in connection with the Motion, the Court deemed the matter appropriate for decision without oral argument. Fed. R. Civ. P. 78; C.D. Cal. L.R. 7-15.

[3] "Certain written instruments attached to pleadings may be considered part of the pleading." *United States v. Ritchie*, 342 F.3d 903, 908 (9th Cir. 2003) (citing Fed. R. Civ. P. 10(c)). "Even if a document is not attached to a complaint, it may be incorporated by reference into a complaint if the plaintiff refers extensively to the document or the document forms the basis of the plaintiff's claim." *Id.* "[T]he district court may treat such a document as part of the complaint, and thus may assume that its contents are true for purposes of a motion to dismiss under Rule 12(b)(6)." *Id.* Here, the Court considers the Policy as incorporated by reference into the FAC because Malibu refers extensively to the Policy, and the Policy forms a substantial basis for Malibu's claims. (*See generally* FAC.)

LK's out-of-pocket maximum had been met, at which point AmeriHealth would pay 100% of UCR (100% of billed charges)." (*Id.* ¶ 39–42.)

Malibu also alleges it obtained "a series of binding pre-authorizations" from Magellan regarding LK's treatment, which are reflected in a series of written confirmation letters (the "Confirmations") sent to Malibu by Magellan. (*Id.* ¶¶ 44, 47–77.) Each Confirmation preauthorized treatment for LK for a given number of days, and each Confirmation also included the following disclaimer:

> Please note that this authorization is not a determination of eligibility or a guarantee of payment. Coverage and payment are subject to the member's eligibility at the time services are provided, and the benefits, limitations, exclusions and other specific terms of the health benefit plan at the time services are provided. The member may be responsible for charges incurred for unauthorized services or for applicable pre-certification penalties. If the member is receiving services from a non-participating provider, the member may have significant higher out-of-pocket expenses than if services are provided by a participating provider.

(FAC Ex. D ("Confirmations"), ECF No. 48-4.) Notwithstanding these disclaimers, Malibu alleges that it relied upon the written authorizations and "rendered the services as specified [in the letters] and timely invoiced AmeriHealth at the rates agreed to during the initial VOB call." (FAC ¶¶ 46, 48–77.)

Malibu acknowledges it "received payment for covered treatment from AmeriHealth for services provided to LK from January 3, 2016 through June 1, 2016." (*Id.* ¶ 81.) But Malibu claims Defendants refused to pay for the services rendered from June 2, 2016 to December 31, 2016, (*id.* ¶ 80), all while Magellan "continued to pre-authorize services for LK performed by Malibu and agreed to pay claims at a specific rate," (*id.* ¶ 82). Malibu alleges that the unpaid amount still owed by AmeriHealth equals $394,985. (*Id.* ¶ 83.)

With respect to Defendants' refusal to pay, Malibu claims that "AmeriHealth and/or Magellan's representatives made numerous, inconsistent statements as to the grounds for claim denial" and gave "arbitrary, inconsistent and unclear justifications

for non-payment in response" to timely filed internal appeals. (*Id.* ¶¶ 85, 86, 88.) Malibu alleges that "[u]ltimately, AmeriHealth and/or Magellan informed Malibu and LK that, without their knowledge or consent, [Defendants] had unilaterally rescinded the [P]olicy at some point in late 2016 or early 2017, despite continuing to accept premium payments and representing active coverage." (*Id.* ¶ 90.)

Based on these and other facts, Malibu asserts the following eight claims against Defendants: (1) violation of California's Unfair Competition Law ("UCL"), California Business and Professions Code section 17200; (2) breach of written contract based on the Confirmations; (3) breach of oral contract; (4) breach of implied contract; (5) promissory estoppel; (6) fraudulent inducement; (7) open book account; and (8) breach of written contract based on the Policy, as assignee and attorney-in-fact. (*See id.* ¶¶ 93–237.) Malibu asserts the first seven claims on behalf of LK, and it asserts the eighth claim in its own name as an assignee and attorney-in-fact. (*See generally id.*)[4] AmeriHealth now moves to dismiss all eight claims against it under Federal Rule of Civil Procedure ("Rule") 12(b)(6) for failure to state a claim. (*See generally* Mot.) AmeriHealth alternatively moves to dismiss Malibu's eighth claim under Rule 12(b)(1) on the ground that Malibu lacks standing. (*See id.* at 10–12).

III. LEGAL STANDARDS

Rule 12(b)(6) provides for dismissal of a complaint for lack of a cognizable legal theory or insufficient facts pleaded to support an otherwise cognizable legal theory. *Balistreri v. Pacifica Police Dep't*, 901 F.2d 696, 699 (9th Cir. 1988). To survive a dismissal motion, a complaint need only satisfy the minimal notice pleading requirements of Rule 8(a)(2)—a short and plain statement of the claim. *Porter v. Jones*, 319 F.3d 483, 494 (9th Cir. 2003). The factual "allegations must be enough to

[4] Before providing treatment to LK, Malibu obtained an Assignment of Benefits (the "Assignment") authorizing Malibu to collect payments directly from AmeriHealth. (FAC ¶ 3; *see* FAC Ex. A ("Assignment"), ECF No. 48-1.) After treatment services were provided, LK executed a Durable Power of Attorney (the "POA") naming Malibu as her attorney-in-fact for all claims related to the recovery of payment for Malibu's treatment services. (FAC ¶ 3; *see* FAC Ex. B ("POA"), ECF No. 48-2.)

raise a right to relief above the speculative level." *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 555 (2007). That is, "a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Twombly*, 550 U.S. at 570).

Rule 12(b)(1) also provides for dismissal of a complaint for lack of subject-matter jurisdiction. The Article III case or controversy requirement limits a federal court's subject-matter jurisdiction by requiring, among other things, that plaintiffs have standing to bring their claims. *Chandler v. State Farm Mut. Auto. Ins. Co.*, 598 F.3d 1115, 1121–22 (9th Cir. 2010). "Rule 12(b)(1) jurisdictional attacks can be either facial or factual." *White v. Lee*, 227 F.3d 1214, 1242 (9th Cir. 2000). When a motion to dismiss attacks subject-matter jurisdiction on the face of the complaint, the court assumes the factual allegations in the complaint are true and draws all reasonable inferences in the plaintiff's favor. *Doe v. Holy See*, 557 F.3d 1066, 1073 (9th Cir. 2009). Moreover, the pleading standards set forth in *Twombly* and *Iqbal* apply with equal force to Article III standing when it is being challenged on the face of the complaint. *See Terenkian v. Republic of Iraq*, 694 F.3d 1122, 1131 (9th Cir. 2012).

The determination of whether a complaint satisfies the plausibility standard is a "context-specific task that requires the reviewing court to draw on its judicial experience and common sense." *Iqbal*, 556 U.S. at 679. A court is generally limited to the pleadings and must construe all "factual allegations set forth in the complaint . . . as true and . . . in the light most favorable" to the plaintiff. *Lee v. City of Los Angeles*, 250 F.3d 668, 679 (9th Cir. 2001). However, a court need not blindly accept conclusory allegations, unwarranted deductions of fact, and unreasonable inferences. *Sprewell v. Golden State Warriors*, 266 F.3d 979, 988 (9th Cir. 2001).

Where a district court grants a motion to dismiss, it should provide leave to amend if the complaint could be saved by amendment. *Manzarek v. St. Paul Fire & Marine Ins. Co.*, 519 F.3d 1025, 1031 (9th Cir. 2008); *see also* Fed. R. Civ.

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