UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

BRIDGEPOINT HEALTHCARE LOUISIANA, LLC d/b/a BRIDGEPOINT CONTINUING CARE HOSPITAL, LLC	**CASE NO.:**
Plaintiff	**JUDGE:**
vs.	
BLUE CROSS BLUE SHIELD NORTH DAKOTA	**MAGISTRATE JUDGE:**
Defendant	

COMPLAINT

NOW COMES BridgePoint Healthcare Louisiana, LLC d/b/a BridgePoint Continuing Care Hospital Louisiana ("BridgePoint" or "Plaintiff"), by and through its undersigned counsel, and for its Complaint hereby states as follows:

Jurisdiction and Venue

1. Jurisdiction of the Court is based upon the Employee Retirement Income Security Act of 1974 ("ERISA") and, in particular, 29 U.S.C. §§ 1132(e)(1) and 1132(f). These provisions give the district courts jurisdiction to hear civil actions brought to recover benefits due under the terms of an Employee Welfare Benefit Plan that, in this case, consists of group healthcare benefits available under such plan (hereinafter referred to as the "Plan") that is provided by Blue Cross Blue Shield of North Dakota ("BCBS ND" or "Defendant") to employees such as the insured (the "Insured").

2. This action may be brought before this Court pursuant to 28 U.S.C. § 1331, which gives the district courts jurisdiction over actions that arise under the laws of the United States.

3. The ERISA statute, 29 U.S.C. § 1133, provides a mechanism for administrative or internal appeal of benefit denials. Plaintiff has exhausted those avenues of appeal. Defendant, BCBS of ND, has failed to give Plaintiff the full and fair hearing to which it is entitled and has failed to respond to its multiple attempts to resolve this matter.

Nature of Action

4. This is a claim seeking an award to Plaintiff of healthcare benefits pursuant to an Employee Welfare Benefit Plan providing group healthcare benefits to Insured. This action, seeking recovery of benefits, is brought pursuant to ERISA § 502(a)(1)(B) [29 U.S.C. § 1132(a)(1)(B)].

The Parties

5. Plaintiff is a foreign Limited Liability Corporation with its registered office in Louisiana located at 9800 Airline Highway, Suite 105, Baton rouge, Louisiana which operates a long term acute care facility ("LTAC") located in Jefferson Parish, Louisiana.

6. Plaintiff provided medical treatment for the Insured between the dates of January 9, 2020 through June 10, 2020.

7. Plaintiff is an assignee of the Insured of benefits of the Plan by virtue of an assignment of insurance benefits (the "Assignment") provided for in the Patient Agreement between Plaintiff and Insured dated January 9, 2021 and executed in Jefferson Parish, Louisiana.

8. Insured was eligible as a qualified employee when Insured's medical condition required treatment at Plaintiff's LTAC.

9. At all times relevant hereto, the Plan constituted an "Employee Welfare Benefit Plan" as defined by 29 U.S.C. § 1002(1) and while employed, Insured had coverage under the Plan

as an employee because Insured was a participant as defined by 29 U.S.C. § 1002(7). This claim relates to benefits assigned by the Insured to Plaintiff under the foregoing Plan.

10. ERISA requires that an Employee Benefit Plan be established and maintained pursuant to a written instrument, 29 U.S.C. § 1102(a)(1).

11. The Plan is a certificate of insurance under which the Insured was a participant at the time of the healthcare claim.

12. BCBS ND is a foreign corporation domiciled in North Dakota, doing business in Louisiana and is the claims administrator, the underwriter, and the Plan administrator of the Plan. Jurisdiction over BCBS ND in this District is being asserted pursuant to 29 U.S.C. § 1132 (e)(2).

13. BCBS ND qualifies as an "affiliate" under that certain Member Provider Agreement ("MPA") between Blue Cross Blue Shield of Louisiana ("BCBS LA") and BridgePoint and is therefore bound by the terms of the MPA.

14. Venue is proper in the Eastern District of Louisiana because the claim originated in Jefferson Parish, Louisiana, the Insured resided in the District at all material times, and all treatment took place in this District. Further, the Assignment and MPA were executed in this District, the oral and written communications which establish a contract between BCBS ND and BridgePoint were directed to this District and all of the relevant events referenced herein occurred in the Eastern District of Louisiana.

Statement of Facts

15. Insured (Beneficiary ID Number 129941972001) was a full-time employee and was actively engaged in employment until on or about December 26, 2019, when Insured required emergency medical treatment at West Jefferson General Hospital.

16. On January 9, 2020, Insured was transferred from West Jefferson General Hospital to BridgePoint's LTAC for long term care at which time BridgePoint obtained the from the Insured.

17. Highmark Health Care Services ("Highmark") acted as an agent for BCBS ND in regard to claims processing matters.

18. On February 1, 2020, Plaintiff was granted pre-approval for treatment of Insured at its LTAC from BCBS ND through its agent, Highmark, authorizing treatment from January 9, 2020 through February 6, 2020.

19. The Insured was treated continuously at the LTAC from January 9, 2020 through June 10, 2020. Treatment beyond the pre-approved date of February 6, 2020 was necessitated by the fact that the Insured had developed an infection which was first detected on January 28, 2020 (prior to the end of the already pre-approved treatment interval). The Insured required continued treatment at the LTAC until June 10, 2020 and BridgePoint provided patient care to the Insured through that date.

20. On March 27, 2020, BCBS ND issued an Approval Notice letter, approving the payment of care for the Insured from January 9, 2021 through January 22, 2021.

21. Also on March 27, 2020, BCBS ND issued a Denial of Benefits letter denying payment for care of the Insured from January 22, 2020 through March 27, 2020 (i.e. the date of the Denial of Benefits letter) stating that the "LTAC stay is denied as not meeting criteria for medical necessity." The Denial of Benefits letter asserted that

> [T]here was no supporting documentation of vent settings that will provide information on: reduction in ventilator support or FiO2 or increase length of spontaneous breathing trial. There were also no supporting documentation of PT/OT and SLP that is required for medical necessity review.

22. On April 13, 2020, Plaintiff sent an Appeal letter to BCBS ND reminding BCBS ND that treatment from January 9, 2020 through February 6, 2020 had been pre-approved and that continued care at Plaintiff's LTAC beyond that date was necessitated by the Insured having developed an infection during Insured's stay. Along with the Appeal letter, Plaintiff provided the Insured's medical records related to Insured's treatment.

23. BCBS ND denied Plaintiff's Appeal on May 13, 2020.

24. On March 18, 2021, outside counsel for Plaintiff sent a follow-up demand for payment for treatment from January 9, 2020 through the date of discharge of the Insured on June 10, 2020.

25. On May 7, 2021, BCBS ND issued a response stating that the majority of Plaintiff's reimbursement request was being denied because BCBS ND determined "these services were not medically necessary and appropriate." BCBS ND did not provide a specific basis for its claim that the medical services provided by Plaintiff were not medically necessary and did not indicate what additional support Plaintiff could submit in order to establish medical necessity beyond the medical records already submitted.

26. In its May 7, 2021, letter, BCBS ND did indicate that Plaintiff's claims for services rendered between January 9, 2020 and January 22, 2020 were qualified for payment but stated that BCBS ND "needed additional information to be submitted in order to process" the claim. However, BCBS ND did not indicate what additional support Plaintiff should submit in order to obtain payment of the charges that BCBS ND itself admitted qualified for reimbursement.

27. The applicable claim regulations under ERISA require that a Plan denial give notification to the Plan beneficiary under 29 C.F.R. § 2560.503-1(g)(1)(i-iv), setting forth: "(i) the specific reason or reasons for the adverse determination; (ii) reference to the specific Plan

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