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Plaintiff is self-represented

Commonwealth of Massachusetts

NANTUCKET, ss.

SUPERIOR COURT DEPARTMENT OF THE TRIAL COURT

Gustavo Kinrys, M.D.,

PLAINTIFF

v.

Blue Cross Blue Shield of Massachusetts, Inc.,

DEFENDANT

SUPERIOR COURT CIVIL ACTION NO.:2375CV00029

DEMAND FOR JURY TRIAL

COMPLAINT

Gustavo Kinrys, M.D. ("Plaintiff"), hereby sues Blue Cross Blue Shield of Massachusetts, Inc. ("Defendant"), alleging as follows:

I. NATURE OF THE ACTION

This action arises from Defendant's systematic and unlawful failure to reimburse Plaintiff for over Fifteen Million Dollars ($15 million) in medical claims submitted from March 2017 to April

2021 for psychiatric services provided to Defendant's members, despite repeated assurances that Plaintiff would be properly reimbursed pursuant to the parties' provider agreement. Blue Cross Blue Shield of Massachusetts, Inc.("BCBSMA"), further interfered with Plaintiff's contractual relationships by terminating his provider status in retaliation for asserting his contractual rights.

II. THE PARTIES

1. Plaintiff is an individual residing in Nantucket, Massachusetts. Plaintiff is a licensed psychiatrist who was credentialed and participated in Defendant's provider network.
2. Upon information and belief, Defendant, BCBSMA, is a health insurance corporation organized under the laws of Massachusetts with its principal place of business in Boston, Massachusetts. BCBSMA is the largest health insurer in the State of Massachusetts and serves nearly three million members. BCBSMA has faced multiple lawsuits on allegations ranging from antitrust violations to consumer fraud and failure to disclose, some resulting in substantial settlements to areas of misconduct that include privacy violations, Medicare overcharging, mental health parity violations, ACA violations, misleading consumer practices, improper claims handling, and abusive utilization review procedures.

III. JURISDICTION AND VENUE

3. This Court has jurisdiction over this matter pursuant to Massachusetts General Laws, (M.G.L.) c. 212, § 4, which grants jurisdiction to the Nantucket Superior Court for civil actions involving breach of contract and violations of Massachusetts Consumer Law (Chapter 93A) over $50,000.

4. Venue is proper in Nantucket County pursuant to M.G.L. c. 223 § 1, as Plaintiff resides in Nantucket County, Massachusetts. Both Plaintiff and Defendant are citizens of Massachusetts.

IV. STATEMENT OF FACTS

5. Plaintiff was a credentialed and participating provider in Defendant's provider network and the parties entered into a Participating Provider Agreement ("Agreement") effective January 1, 2010.
6. Pursuant to the Agreement and its payment policies (Exhibit A), Defendant is obligated to reimburse Plaintiff for covered medical services provided to Defendant's members at the negotiated contract rates (Exhibits B).
7. From October 2017 to April 2021, Plaintiff rendered covered medical services to Defendant's members as outlined in over 5,000 separate claims submitted to Defendant.
8. Defendant has systematically refused to reimburse Plaintiff for any of these claims, which now total over Fifteen Million Dollars ($15 million) in billed charges.
9. Defendant's refusal to reimburse Plaintiff's claims constitutes a material breach of the Agreement.
10. On multiple occasions Plaintiff inquired as to the status of its unpaid claims and when reimbursement could be expected.
11. In response, Defendant assured Plaintiff that the claims were being processed and reimbursement would be issued promptly pursuant to the Agreement.
12. At the time such assurances were made, Defendant knew they were deceptive and misleading and had no intention to properly reimburse Plaintiff's claims.

13. Defendant's actions constitute unfair and deceptive trade acts and practices under M.G.L. c. 93A.
14. Plaintiff made numerous written and oral demands for reimbursement, all of which were ignored by Defendant without explanation.
15. Defendant provided shifting and inconsistent reasons for non-payment of claims, none of which are valid under the Agreement.
16. Defendant subjected Plaintiff to an onerous pre-authorization process not required under the Agreement, causing significant delays.
17. Defendant interfered with Plaintiff's business relationships with patients by deceptively representing that Plaintiff was intentionally overbilling.
18. In or around December 2018, Defendant apparently opened a fraud investigation against Plaintiff regarding the unpaid claims and accused Plaintiff of intentionally overbilling and providing medically unnecessary services.
19. Defendant accused Dr. Kinrys of fraudulent billing practices, when in reality, Defendant was systemically breaching the provider agreement by refusing to reimburse over 5,000 properly documented claims worth over $15 million. Defendant levied its spurious fraud allegations to deter Dr. Kinrys from pursuing compensation for services rendered to Defendant's members in good faith reliance on the provider agreement.
20. Defendant levied these accusations without any evidence of actual fraud by Plaintiff.
21. Defendant did not have any good faith basis to allege fraud, but instead made these allegations in order to intimidate Plaintiff from seeking reimbursement and to avoid its contractual obligations.
22. Defendant threatened criminal prosecution against Plaintiff if the overbilling was not corrected, even though Defendant knew the billing was proper under the Agreement.

23. Defendant continued to represent to patients and others in the community that Plaintiff was under fraud investigation and patients should avoid Plaintiff's services.
24. Defendant's misleading and deceptive fraud allegations were made intentionally and maliciously to harm Plaintiff's reputation and ability to seek reimbursement.
25. Immediately after opening the fraud investigation in December 2018, Defendant began auditing every single claim submitted by Plaintiff, which amounted to over 5,000 claims.
26. Defendant used the opened investigation as a pretense to deny reimbursement on claims it had previously verified and approved.
27. Defendant claimed it could not pay the claims until it received and reviewed all medical records, even though Plaintiff consistently provided all requested records.
28. Throughout the alleged fraud investigation, Defendant continued to review and approve Plaintiff's requests for prior authorization on specific services and treatments. Defendant granted these prior authorizations, allowing Plaintiff to provide the authorized services to Defendant's members with the understanding that Plaintiff would be properly reimbursed. However, despite of reviewing and approving the services and Plaintiff providing them in reliance on that approval, Defendant still refused to render payment for those very same services.
29. Over the next two years, Defendant continued to assure Dr. Kinrys that his claims were being processed and would be paid in due course. However, Defendant knew these representations were misleading and deceptive, and that it had implemented internal policies to intentionally delay and deny reimbursement for Dr. Kinrys' services.
30. When Plaintiff inquired about ceasing services to Defendant's members due to non-payment, Defendant urged Plaintiff to continue providing services, representing that reimbursement would be made once the records were received.

31. At the same time, Defendant continued telling patients and others that Plaintiff was under fraud investigation to avoid paying claims.
32. Defendant undertook this expanded audit and records request process in bad faith solely to impose additional costs on Plaintiff and deter Plaintiff from seeking proper reimbursement.
33. In or around June 2019, after Plaintiff's unpaid claims reached over $15 million, Defendant performed an internal audit and determined the amount Defendant actually owed Plaintiff far exceeded the overbilling amount alleged in Defendant's fraud investigation.
34. Upon realizing this, Defendant made the decision to terminate Plaintiff from its provider network in order to further avoid paying the owed reimbursements.
35. Defendant was aware Plaintiff was prepared to take legal action over the unpaid claims, as Plaintiff's attorneys contacted Defendant in August 2019 requesting mediation.
36. Rather than mediate in good faith, Defendant chose to retaliate against Plaintiff by sending notification of Plaintiff's termination from the provider network effective on December 2019.
37. Defendant's termination of Plaintiff came directly on the heels of Plaintiff's demands for payment and threats of litigation, evidencing the termination was done intentionally to punish Plaintiff for asserting its contractual rights.
38. BCBSMA has an extensive history of legal and regulatory actions taken against it for violating consumer protection and healthcare laws. This includes privacy breaches affecting hundreds of thousands of consumers, overcharging Medicare Advantage customers in violation of rate regulations, systematically denying mental health coverage

in violation of parity laws, failing to provide required coverage under the ACA, and misleading subscribers about policy exclusions.

39. Additionally, BCBSMA has faced complaints and lawsuits accusing it of improper claims handling and reimbursement practices such as denying or reducing payment to subscribers and providers, utilizing inconsistent and burdensome pre-authorization procedures that harm access to care, and subjecting claims to inadequate and biased reviews in order to restrict payment. This broad pattern of misconduct under Massachusetts and federal healthcare laws provides further support that BCBSMA has engaged in similarly unlawful practices in its dealings with Plaintiff.
40. As part of this scheme, Plaintiff alleges that Defendant engaged in concerted action with federal prosecutors, exchanging misleading and deceptive information, fabricating evidence, and exerting influence over the prosecution process to initiate sham investigations against Plaintiff and other healthcare providers.
41. Defendant conspired with federal prosecutors in an unlawful collaboration aimed at violating Plaintiff's constitutional rights and retaliating against providers who asserted their legal rights for proper reimbursement.
42. This concerted action was not limited to Plaintiff alone; other providers faced similar retaliation and unfounded investigations due to Defendant's connections with prosecutors, establishing a pattern of coordinated action.
43. Plaintiff contends that Defendant and federal prosecutors formed a joint enterprise with a common purpose and design to retaliate against healthcare providers, including Plaintiff, by leveraging improper criminal charges.
44. Defendant and prosecutors acted in cooperation and coordination, initiating fraudulent investigations and fabricating evidence to target Plaintiff and other providers unfairly.

45. The existence of other providers who were similarly targeted and victimized by this joint enterprise serves as additional evidence of its deliberate and patterned operation.
46. Defendant maintains established connections with federal and state law enforcement agencies, including the Office of the Inspector General, the Department of Human health Services, US Attorney's Office, and the Massachusetts Attorney General's Office. Defendant has leveraged these connections on multiple occasions in the past decade to initiate unjustified investigations against select physicians and medical practices.
47. Typically, the targets of these improper investigations are providers who Defendant considers "expensive outliers" due to higher than average reimbursement claims. Defendant makes use of intentional misinformation provided to law enforcement and elected officials to spur sham investigations meant to intimidate the providers.
48. Once a retaliatory investigation is opened, Defendant utilizes it as pretext to terminate or refuse to reimburse the affected providers. This pattern of weaponizing law enforcement connections to influence investigations, trigger prosecutions on misleading and deceptive pretenses, and coordinate termination of the targeted providers constitutes an improper and extortionate enterprise.
49. Plaintiff alleges that Defendant Blue Cross Blue Shield of Massachusetts (BCBSMA) engaged in an unlawful concerted scheme with federal prosecutors to target certain healthcare providers. Specifically, Plaintiff contends that BCBSMA collaborated with prosecutors to exchange fabricated evidence and misleading and deceptive information about Plaintiff and other providers. BCBSMA then leveraged its connections to influence sham criminal investigations against these providers in retaliation for their complaints against BCBSMA's reimbursement practices.

50. BCBSMA and federal prosecutors operated as a joint enterprise with the common purpose of denying providers their rights and avoiding BCBSMA's civil liability. This joint enterprise involved coordination between BCBSMA and prosecutors to manufacture criminal cases against vocal providers like Plaintiff through improper means.
51. Plaintiff highlights that over the past 30 years and as recently as July 2023, BCBSMA has faced multiple government lawsuits regarding its fraudulent schemes against Medicare and other programs, resulting in substantial civil settlements. However, despite this lengthy history of systemic misconduct, BCBSMA has evaded any criminal prosecution through its undue influence over state and federal agencies.
52. In contrast, Plaintiff alleges that BCBSMA has manipulated prosecutors to criminally charge individual providers who dare to assert legal rights against BCBSMA's wrongdoing. By deflecting scrutiny onto solitary providers, BCBSMA shields itself from accountability while still improperly avoiding payment to providers. This amounts to an egregious double standard that must be exposed.
53. Furthermore, Plaintiff contends that BCBSMA and federal prosecutors formed a joint enterprise with a common purpose and design to retaliate against healthcare providers, including Plaintiff, by leveraging improper criminal charges. The joint enterprise involved a systematic coordination of actions, including fraudulent investigations and fabrication of evidence, targeting Plaintiff and other providers in an unfair manner.
54. It is essential to highlight that BCBSMA's repeated involvement in lawsuits with the federal government over the last 30 years further substantiates the claims of concerted action and joint enterprise. Despite facing such legal actions, BCBSMA consistently settled these matters by paying fines and penalties, thus skillfully avoiding criminal prosecution. To gain favor from state and federal agencies, BCBSMA actively utilized its

connections to hand-deliver individual providers that they deemed troublesome. Through this strategic approach, BCBSMA managed to evade payment to these providers, while simultaneously maintaining a status of avoiding criminal charges. Instead, they only faced civil actions, which ultimately culminated in settlements without any criminal consequences.

55. The shocking aspect is the egregious and recurrent pattern of BCBSMA breaking the law, involving fraudulent practices on a scale 100-fold greater than that of individual providers who end up facing criminal charges by the federal government. Despite these glaring disparities, BCBSMA's efforts to manipulate and influence state and federal agencies have enabled them to remain insulated from criminal prosecution, perpetuating their unjust practices while escaping criminal accountability.

V. STATEMENT OF CLAIMS

COUNT I - BREACH OF CONTRACT

56. Plaintiff fully incorporates by reference Paragraphs 1-55 as if fully stated herein.
57. The Agreement between Plaintiff and Defendant is a valid and enforceable contract.
58. Plaintiff has complied with all terms and conditions of the Agreement.
59. By failing and refusing to reimburse Plaintiff's claims as required by the Agreement, Defendant has breached the Agreement.
60. As a direct result of Defendant's breach, Plaintiff has suffered damages in excess of $20 million.

COUNT II - M.G.L. c. 93A VIOLATIONS

61. Plaintiff fully incorporates by reference Paragraphs 1-60 as if fully stated herein.

62. Defendant's assurances that Plaintiff's claims were being processed and would be reimbursed, when in fact Defendant had no intention of paying the claims, constitute unfair and deceptive trade acts and practices under M.G.L. c. 93A.
63. These unfair and deceptive acts occurred primarily in Massachusetts.
64. As a direct result of Defendant's unfair and deceptive acts and practices, Plaintiff has suffered damages in excess of $20 million.

COUNT III - PROMISSORY ESTOPPEL:

65. Plaintiff fully incorporates by reference Paragraphs 1-64 as if fully stated herein.
66. Defendant, through its representatives, made clear and unambiguous promises that Plaintiff's claims for medical services would be properly reimbursed pursuant to the Provider Agreement.
67. Defendant reasonably expected these promises would induce Plaintiff to continue providing medical services to Defendant's members.
68. Plaintiff justifiably and foreseeably relied on Defendant's promises by continuing to provide covered services to Defendant's members per the Agreement, despite non-payment.
69. Plaintiff suffered substantial detriment due to its reliance on Defendant's promises, including staff costs, equipment costs, opportunity costs, and loss of profits.
70. Injustice can only be avoided by enforcing Defendant's promises of reimbursement.
71. Defendant is therefore estopped from withholding payment for the claims and Plaintiff is entitled to recover damages resulting from its reasonable reliance.

COUNT IV - INTENTIONAL INTERFERENCE WITH CONTRACTUAL/BUSINESS RELATIONS:

72. Plaintiff fully incorporates by reference Paragraphs 1-71 as if fully stated herein.

73. Plaintiff had valid business relationships with patients covered by Defendant's plans.

74. Defendant knowingly interfered with these relationships through misleading and deceptive representations regarding billing practices.

75. Defendant's actions were improper, intentional, and malicious.

76. Plaintiff suffered damages as a result.

COUNT V - DEFAMATION:

77. Plaintiff fully incorporates by reference Paragraphs 1-76 as if fully stated herein.

78. Defendant made misleading and deceptive and defamatory written and oral statements accusing Plaintiff of fraudulent overbilling of medical claims.

79. Defendant published these misleading and deceptive statements to third parties, including patients of Plaintiff, and regulatory agencies.

80. At the time the statements were made, Defendant knew they were misleading and deceptive or acted in reckless disregard as to the truth of the statements. These misleading and deceptive statements harmed Plaintiff's reputation and good will as a medical provider in the community.

81. Plaintiff suffered economic and reputational damages as a direct and proximate result of Defendant's misleading and deceptive and defamatory statements.

82. Therefore, Defendant has defamed Plaintiff and Plaintiff is entitled to compensatory damages, punitive damages, and any other relief afforded under the law.

COUNT VI - VIOLATION OF UNFAIR CLAIMS SETTLEMENT PRACTICES REGULATIONS:

83. Plaintiff fully incorporates by reference Paragraphs 1-82 as if fully stated herein.

84. Defendant, as a health insurance corporation, is subject to state insurance regulations, including Unfair Claims Settlement Practices Regulations.
85. Defendant's systematic refusal to reimburse Plaintiff for valid medical claims constitutes a violation of these Unfair Claims Settlement Practices Regulations.
86. Such violations demonstrate a pattern of unfair and deceptive practices in handling claims, resulting in harm to Plaintiff.
87. As a direct result of these violations, Plaintiff has suffered damages in excess of $20 million.

COUNT VII - NEGLIGENT MISREPRESENTATION:

88. Plaintiff fully incorporates by reference Paragraphs 1-87 as if fully stated herein.
89. In deceptively assuring Plaintiff that its claims were being processed and would be reimbursed, Defendant negligently misrepresented the status of the claims and Defendant's intention to reimburse.
90. Defendant owed Plaintiff a duty to provide accurate and truthful information regarding the claims.
91. Defendant's misleading and deceptive representations induced Plaintiff to rely on such assurances and continue providing services to Defendant's members.
92. Plaintiff suffered financial losses and damages due to its reasonable reliance on Defendant's negligent misrepresentations.

COUNT VIII - TORTIOUS INTERFERENCE WITH ECONOMIC RELATIONS:

93. Plaintiff fully incorporates by reference Paragraphs 1-92 as if fully stated herein.
94. Plaintiff had established business relationships with patients and other providers in the community.

95. Defendant intentionally and improperly interfered with these economic relations through misleading and deceptive fraud allegations and threats of criminal prosecution.
96. Defendant's actions were undertaken with the purpose of damaging Plaintiff's reputation and economic interests.
97. As a direct and proximate result of Defendant's tortious interference, Plaintiff suffered significant economic harm, including loss of patients and business opportunities.

COUNT IX - VIOLATION OF MENTAL HEALTH PARITY ACT:

98. Plaintiff fully incorporates by reference Paragraphs 1-97 as if fully stated herein.
99. The Mental Health Parity Act requires insurers to provide equal coverage for mental health services as they do for medical or surgical services.
100. Defendant's refusal to reimburse Plaintiff for psychiatric services provided to Defendant's members constitutes a violation of the Mental Health Parity Act.
101. Plaintiff is entitled to damages resulting from Defendant's failure to comply with the Act, which includes the value of the unpaid claims and additional costs incurred by Plaintiff due to the denial of reimbursement.

COUNT X - BREACH OF THE DUTY OF GOOD FAITH AND FAIR DEALING:

The Agreement between Plaintiff and Defendant imposes a duty of good faith and fair dealing in the performance and enforcement of the contract.

102. Plaintiff fully incorporates by reference Paragraphs 1-101 as if fully stated herein.
103. Defendant's systematic refusal to reimburse Plaintiff for valid medical claims, despite assurances of prompt payment, constitutes a breach of the duty of good faith and fair dealing.

104. Defendant's actions were intentional and designed to withhold proper reimbursements owed to Plaintiff, thereby violating the fundamental principles of fair dealing under the Agreement.

COUNT XI - VIOLATION OF THE RACKETEER INFLUENCED AND CORRUPT ORGANIZATIONS ACT (RICO):

105. Plaintiff fully incorporates by reference Paragraphs 1-104 as if fully stated herein.

106. Defendant's pattern of deceptive practices, including making misleading and deceptive fraud referrals and fabricating documents to initiate sham investigations, constitutes a violation of the Racketeer Influenced and Corrupt Organizations Act (RICO).

107. Defendant's actions were part of an ongoing scheme to defraud healthcare providers and unlawfully withhold reimbursements.

108. Defendant engaged in interstate mail and wire fraud by using electronic and postal communications to further schemes to defraud healthcare providers of proper payments. This involves a pattern of racketeering activities across state lines to further Defendant's fraudulent reimbursement schemes and retaliation against providers who assert their legal rights. Defendant's coordinated fraudulent actions violate Federal RICO statutes.

109. Defendant's conduct harmed Plaintiff's business and financial interests and was done with the intent to further its fraudulent practices.

110. As a direct result of Defendant's RICO violations, Plaintiff has suffered substantial damages and financial losses.

COUNT XII - VIOLATION OF THE MEDICAL LOSS RATIO REQUIREMENTS:

111. Plaintiff fully incorporates by reference Paragraphs 1-110 as if fully stated herein.

112. The Affordable Care Act (ACA) imposes Medical Loss Ratio (MLR) requirements on health insurers, including Defendant.

113. Defendant's systematic refusal to reimburse Plaintiff for valid medical claims resulted in an inflated MLR, wherein Defendant failed to meet the ACA's mandated percentage of premiums spent on medical claims.

114. By not meeting the MLR requirements, Defendant violated the ACA and caused harm to Plaintiff by withholding rightful reimbursements and unfairly skewing its financial performance.

115. Plaintiff is entitled to damages resulting from Defendant's failure to comply with the ACA's MLR requirements.

COUNT XIII - INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS:

116. Plaintiff fully incorporates by reference Paragraphs 1-115 as if fully stated herein.

117. Defendant's deliberate and malicious actions, including misleadingly and deceptively accusing Plaintiff of fraud, interfering with patient relationships, and withholding reimbursements, were extreme and outrageous conduct.

118. Defendant's intentional conduct caused Plaintiff severe emotional distress and anxiety.

119. Defendant's actions were done with the intent to cause emotional harm to Plaintiff, and such harm was a foreseeable consequence of Defendant's conduct.

120. As a direct result of Defendant's intentional infliction of emotional distress, Plaintiff has suffered significant emotional harm and is entitled to compensatory and punitive damages.

COUNT XIV - VIOLATION OF ANTI-KICKBACK STATUTES:

121. Plaintiff fully incorporates by reference Paragraphs 1-120 as if fully stated herein.

122. In a calculated effort to undermine Plaintiff's services and hinder Plaintiff's reimbursement claims, Defendant embarked on a series of unlawful kickback arrangements with other healthcare providers.

123. The actions of Defendant are unequivocally in violation of federal and state Anti-Kickback Statutes, laws designed to safeguard the integrity of healthcare transactions by prohibiting inducements that promote improper financial gains at the expense of other providers.

124. Through these illicit kickback arrangements, Defendant deliberately engaged in a web of fraudulent and illegal practices, systematically disadvantaging other providers like Plaintiff and inflicting substantial harm upon Plaintiff's financial interests and crucial business relationships.

125. As a direct consequence of Defendant's deliberate violation of the Anti-Kickback Statutes, Plaintiff has incurred tangible damages, thereby entitling Plaintiff to rightful compensation commensurate with the harm inflicted upon them.

COUNT XV - VIOLATION OF ERISA:

126. Plaintiff fully incorporates by reference Paragraphs 1-125 as if fully stated herein.

127. Defendant's systematic failure to reimburse Plaintiff for valid medical claims constitutes a violation of the Employee Retirement Income Security Act (ERISA).

128. As a health insurance corporation providing coverage under employer-sponsored health plans, Defendant is subject to ERISA's fiduciary duty requirements to process claims accurately and promptly.

129. Defendant's willful denial of reimbursement claims and improper handling of claims is a breach of its fiduciary duties under ERISA.

130. Plaintiff, as a provider of services under ERISA-governed plans, is entitled to damages resulting from Defendant's ERISA violations, which includes the value of unpaid claims and other related losses.

COUNT XVI - CONSPIRACY TO VIOLATE CIVIL RIGHTS:

131. Plaintiff fully incorporates by reference Paragraphs 1-130 as if fully stated herein.

132. Plaintiff contends that Defendant engaged in an intentional, coordinated scheme to deprive healthcare providers of fundamental Constitutional protections. Specifically, when faced with the prospect of civil actions and liability for its own alleged misconduct, Defendant conspired with federal prosecutors to manufacture fabricated criminal prosecutions against targeted providers like Plaintiff. Defendant collaborated to supply prosecutors with misleading and deceptive information aimed at spurring baseless criminal investigations as retribution for potential civil claims, though Plaintiff had engaged in no criminal wrongdoing whatsoever.

133. By intentionally weaponizing the criminal justice process to deter and obstruct providers' lawful pursuit of civil remedies, Defendant blatantly violated their First Amendment rights to petition the government for redress of grievances. Furthermore, Defendant's calculated scheme to deny providers equal justice under law flies in the face of Fourteenth Amendment guarantees of due process and equal protection. In short, Defendant sought to manipulate the machinery of criminal prosecution for the unlawful purpose of denying providers' civil rights to fair legal process.

134. This coordinated obstruction of Constitutional safeguards is the epitome of an insidious conspiracy against rights. Such abuse of prosecutorial mechanisms for the purpose of denying Constitutional rights amounts to a direct violation of civil rights under color of law.

135. Plaintiff alleges that Defendant engaged in an intentional, coordinated scheme to deprive healthcare providers of their Constitutional rights by conspiring with federal prosecutors

to manufacture fabricated criminal prosecutions against providers in retaliation for potential civil claims against Defendant.

136. Defendant's coordinated scheme to obstruct Constitutional safeguards through prosecutorial collusion constitutes an egregious conspiracy against civil rights through the denial of due process.

137. Plaintiff alleges Defendant conspired with prosecutors to devise meritless criminal allegations against providers in direct response to and in anticipation of their lawful civil claims against Defendant, in order to obstruct providers' civil rights to access the courts and receive equal justice under law.

COUNT XIX - ANTITRUST VIOLATIONS

138. Plaintiff fully incorporates by reference Paragraphs 1-137 as if fully stated herein.

139. Defendant has monopolistic control over the health insurance market in Massachusetts. It uses this dominance to impose unreasonable reimbursement restrictions and unfair claim procedures on network providers. This amounts to illegal restraint of trade and reduction of competition among insurers and in the healthcare market generally.

140. Evidence unequivocally demonstrates that Defendant, wielding monopolistic control over the health insurance market in Massachusetts, has systematically exploited this supremacy to impose egregiously unreasonable reimbursement restrictions and propagate patently unfair claim procedures upon the providers within its network.

141. These practices, amounting to a calculated manipulation of the market dynamics, blatantly disregard the principles of free competition and market equilibrium that antitrust laws are specifically designed to protect.

142. Defendant's continuous abuse of its dominant position has wrought a palpable restraint on trade that is both patently illegal and in flagrant violation of the fundamental principles of competition enshrined in antitrust laws.

143. By engaging in these anticompetitive maneuvers, Defendant has willfully diminished the potential for fair competition among insurers and has exacerbated the overall deterioration of competition within the broader healthcare landscape.

144. In light of these egregious actions, Defendant's culpability in violating antitrust laws is irrefutable, as evidenced by their calculated attempts to stifle competition, inhibit market fluidity, and perpetuate their own monopolistic control to the detriment of providers like Plaintiff.

145. The resulting damages accrued by Plaintiff as a direct consequence of Defendant's flagrant antitrust violations merit just compensation, underscoring the necessity for legal intervention to rectify the injustices perpetrated upon Plaintiff and other similarly affected providers.

COUNT XX - CONSUMER PROTECTION VIOLATIONS

146. Plaintiff fully incorporates by reference Paragraphs 1-145 as if fully stated herein.

147. Defendant engaged in unfair and deceptive practices by making misleading and deceptive representations to induce providers to join its network, then manipulating improper justifications to avoid rendering payment. These fraudulent acts violate Massachusetts consumer protection laws.

148. Defendant's conduct, marked by its consistent pattern of deceit and unfairness, constitutes an egregious violation of Massachusetts consumer protection laws, underscoring its wanton disregard for the ethical treatment of healthcare providers.

149. By adopting an approach characterized by misleading and deceptive representations, Defendant willfully misled providers, including Plaintiff, into joining its network under the false pretense of ethical business conduct and equitable reimbursement practices.

150. However, far from adhering to its promises, Defendant intentionally manipulated and distorted its reimbursement procedures, utilizing unfounded justifications to evade its duty to render rightful payments to providers for services rendered.

151. Defendant's blatant disregard for ethical and lawful business practices directly contradicts the essence of consumer protection laws, which were explicitly enacted to shield individuals and entities from deceptive trade acts and practices.

152. The actions of Defendant embody a calculated strategy designed to mislead providers into a false sense of security, only to exploit their trust and reap the financial benefits while unfairly withholding the due reimbursement.

153. By perpetuating this cycle of deception, manipulation, and breach of trust, Defendant has unequivocally engaged in fraudulent acts that flagrantly contravene the principles of Massachusetts consumer protection laws.

154. The damages incurred by Plaintiff as a result of Defendant's pervasive consumer protection violations are not only monetary but extend to the realm of reputational harm, underscoring the urgency for legal intervention to rectify the extensive injustices perpetrated upon Plaintiff and other providers similarly affected by Defendant's unscrupulous practices.

COUNT XXI - FRAUDULENT INDUCEMENT

155. Plaintiff fully incorporates by reference Paragraphs 1-154 as if fully stated herein.

156. Defendant made misleading and deceptive representations to Plaintiff, including promises of prompt reimbursement and full subscriber access, to induce Plaintiff to continue to provide services to its Members and remain an in-network provider through its provider agreement.

157. Defendant had knowledge of the falsity of these promises, as evidenced by past breaches of identical promises to other providers in its network.

158. Plaintiff relied on Defendant's misleading and deceptive representations and suffered financial harms as a result of remaining an in-network provider and participant in the provider agreement.

COUNT XXII - CONCERTED ACTION

159. Plaintiff fully incorporates by reference Paragraphs 1-158 as if fully stated herein.

160. Defendant acted in concert with federal prosecutors, exchanging misleading and deceptive information, fabricating evidence, and influencing the prosecution to initiate sham investigations against Plaintiff and other providers.

161. Plaintiff fully incorporates by reference Paragraphs 1-154 as if fully stated herein.

162. Defendant conspired with federal prosecutors to violate Plaintiff's constitutional rights and retaliate against providers who asserted their legal rights for proper reimbursement.

163. Other providers similarly suffered retaliation through Defendant's connections with prosecutors, establishing a pattern of concerted action.

COUNT XXIII - JOINT ENTERPRISE

164. Plaintiff fully incorporates by reference Paragraphs 1-163 as if fully stated herein.

165. Defendant and federal prosecutors engaged in a joint enterprise with a common purpose and design to retaliate against troublesome providers through improper criminal charges.

166. Defendant and prosecutors cooperated and coordinated efforts to initiate fraudulent investigations and fabricate evidence against Plaintiff and other targeted providers. Examples of other providers similarly targeted further substantiate the existence of a joint enterprise and its pattern of operation.

COUNT XXIV - DECEPTIVE BUSINESS PRACTICES

167. Plaintiff fully incorporates by reference Paragraphs 1-166 as if fully stated herein.

168. Defendant engaged in deceptive business practices by deceptively representing to providers that they would be properly reimbursed for services rendered, inducing them to join Defendant's network.

169. After providers joined the network, Defendant manipulated improper justifications to avoid rendering payment, continuing its deceptive practices to maximize its financial gains.

170. Defendant's deceptive practices violated Massachusetts consumer protection laws and caused harm to providers, including Plaintiff.

COUNT XXV - VIOLATION OF MASSACHUSETTS INSURANCE LAWS

171. Plaintiff fully incorporates by reference Paragraphs 1-170 as if fully stated herein.

172. Defendant violated Massachusetts insurance laws by engaging in unfair and deceptive reimbursement practices, failing to fulfill contractual obligations, and retaliating against providers who sought rightful reimbursements.

173. Defendant's actions contravened the principles of good faith and fair dealing required under Massachusetts insurance laws, causing financial harm to Plaintiff.

COUNT XXVI - BREACH OF FIDUCIARY DUTY

174. Plaintiff fully incorporates by reference Paragraphs 1-173 as if fully stated herein.

175. As a health insurance corporation, Defendant owed a fiduciary duty to providers in its network, including Plaintiff, to act in their best interests regarding claims processing and reimbursement.

176. Defendant breached its fiduciary duty by systematically withholding proper payments, imposing unreasonable reimbursement restrictions, and using improper claim procedures to favor its financial interests over the providers' interests.

COUNT XXVII - RETALIATION AGAINST WHISTLEBLOWER

177. Plaintiff fully incorporates by reference Paragraphs 1-176 as if fully stated herein.

178. Defendant retaliated against Plaintiff as a whistleblower who asserted his contractual rights and reported Defendant's fraudulent practices to regulatory authorities.

179. In response to Plaintiff's demands for payment and threats of litigation, Defendant terminated Plaintiff from its provider network in December 2019, showing direct retaliation for whistleblowing.

COUNT XXVIII - VIOLATION OF FEDERAL AND STATE PRIVACY LAWS

180. Plaintiff fully incorporates by reference Paragraphs 1-179 as if fully stated herein.

181. Defendant violated federal and state privacy laws by sharing misleading and deceptive information about Plaintiff's alleged fraudulent activities with third parties, including patients and others in the community, without valid legal basis.

182. Defendant's actions harmed Plaintiff's reputation and violated his privacy rights, leading to economic and reputational damages.

COUNT XXIX. TORTIOUS INTERFERENCE WITH CURRENT AND PROSPECTIVE CONTRACTUAL RELATIONS

183. Plaintiff fully incorporates by reference Paragraphs 1-182 as if fully stated herein.

184. Defendant tortiously interfered with Plaintiff's contractual relationships with patients by deceptively representing that Plaintiff engaged in fraudulent overbilling and providing medically unnecessary services.

185. Defendant's misleading and deceptive fraud allegations were intentional and malicious, aiming to harm Plaintiff's reputation and deter patients from seeking his services.

COUNT XXX - VIOLATION OF HEALTHCARE PROVIDER ANTI-RETALIATION LAWS

186. Plaintiff fully incorporates by reference Paragraphs 1-185 as if fully stated herein.

187. Defendant violated healthcare provider anti-retaliation laws by terminating Plaintiff from its network in retaliation for asserting his contractual rights and pursuing proper reimbursements.

188. Plaintiff's termination was directly linked to his demands for payment and threats of litigation, demonstrating clear retaliation by Defendant.

COUNT XXXI - FRAUDULENT MISREPRESENTATION

189. Plaintiff fully incorporates by reference Paragraphs 1-188 as if fully stated herein.

190. Defendant, through its authorized representatives, knowingly made numerous false statements of material fact to Plaintiff regarding the terms of the provider agreement and reimbursement of claims.

191. These false representations included that Defendant would reimburse claims within 30 days of receipt, provide prompt pre-authorization decisions, give full access to all insured patients, and process all claims in good faith pursuant to contractual guidelines.

192. At the time these promises and representations were made, Defendant knew they were false and had no intention of complying with them.

193. Defendant made the false representations with the intent of fraudulently inducing Plaintiff to comply with the provider agreement and to continue providing services to Defendant's insured patients.

194. Plaintiff justifiably relied on Defendant's misrepresentations by entering into the agreement, rendering services to patients, and expending costs for staff and operations.

195. As a direct result of its reasonable reliance on Defendant's fraudulent statements, Plaintiff has suffered damages through lost income, unpaid reimbursement, and operational costs.

196. Defendant is liable for fraudulent misrepresentation under Massachusetts law. Plaintiff is entitled to damages and equitable relief due to Defendant's intentional deception.

VI. PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays for judgment against Defendant as follows:

a) Actual, compensatory, and consequential damages in excess of $20 million;

b) Double or treble damages under M.G.L. c. 93A;

c) Plaintiff seeks an injunction prohibiting Defendant from further unfair claims practices, arguing that without such injunctive relief it will suffer irreparable harm, the balance of equities favors Plaintiff, and the public interest would be served.

d) Restitution and disgorgement of any ill-gotten gains obtained by Defendant as a result of their unlawful conduct;

e) Compensatory, incidental, and punitive damages in an amount to be determined at trial, but expected to substantially exceed One Hundred Million Dollars ($100,000,000);

f) Creation of a non-profit foundation, funded with the largest portion of the relief awarded in this case, in the amount of One Hundred Million Dollars ($100,000,000), to disburse

funds to healthcare providers who have been victims of BCBSMA's abuses, providing financial compensation for their losses;

g) The non-profit foundation shall also provide legal assistance to healthcare providers victims at no cost, ensuring that affected individuals have access to the legal representation necessary to protect their rights;

h) Plaintiff also seeks a separate injunction reinstating its status as an in-network provider, arguing irreparable harm from loss of patient relationships, balance of equities in its favor, and service of the public interest.

i) Costs, interest, and reasonable attorney's fees; and

j) Such other and further relief as the Court deems just and proper.

IX. DEMAND FOR JURY TRIAL

The Plaintiff demands a trial by jury on all issues so triable.

I, Gustavo Kinrys, the Plaintiff in the above-captioned action, hereby verify under the pains and penalties of perjury that the facts set forth in the foregoing Complaint are true and correct to the best of my knowledge, information, and belief.

Dated: 08/08/2023

Respectfully submitted.

/s/ Gustavo Kinrys

Plaintiff's signature
Self-represented

Name: Gustavo Kinrys
Address: 4 Goose Cove Way
Nantucket, MA 02554
Telephone No.: 617-953-8282

EXHIBIT A

Mental Health & Substance Use Disorders

MASSACHUSETTS

Policy

Blue Cross Blue Shield of Massachusetts (Blue Cross*) reimburses contracted providers for covered, medically necessary mental health and substance use services.

General benefit information

Covered services and payment are based on the member's benefit plan and provider Agreement. Providers and their office staff may use our online tools to verify effective dates and member copayments before providing services. Visit our eTools page for information on member eligibility and benefits. Member liability may include, but is not limited to: copayments, deductibles, and co-insurance. Members' costs depend on member benefits.

Certain services require prior authorization or referral.

Payment information

Blue Cross reimburses health care providers based on your contracted rates and member benefits.

Claims are subject to payment edits, which Blue Cross updates regularly.

Access to care: mental health services for managed care members

- Primary care providers (PCPs, NPPCPs, PAPCPs) or members themselves may arrange for mental health services.
- If members initiate care, they should call the behavioral health phone number on the back of their member ID card before treatment to determine the scope of benefits available and to locate a participating mental health provider.
- Members can find a mental health provider by using the Find a Doctor & Estimate Costs feature on our member website, bluecrossma.org.
- Providers can use Find a Doctor & Estimate Costs from Provider Central.

Blue Cross reimburses services when medically necessary and according to medical policy guidelines.

Mental health

- Psychiatric diagnostic services and procedures
- Individual psychotherapy
- Interactive psychotherapy
- Esketamine and IV Ketamine therapy per medical policy
- Family psychotherapy
- Group psychotherapy
- Electroconvulsive therapy (ECT)
- Psychological and neuropsychological tests
- Transcranial magnetic stimulation
- Intensive Community-Based Treatments (ICBT), which include in-home behavioral services (IHBS), in-home therapy (IHT), and intensive care coordination (ICC), to treat child-adolescent mental health disorders as listed on the community mental health center fee schedule and when reported with the HK modifier
- Two additional services to Intensive Community-Based Treatments (ICBT): Therapeutic Mentoring (TM) and Family Support and Training (FS&T) to treat child-adolescent mental health disorders as listed on the community mental health center fee schedule and when reported with the HK modifier
- Expedited psychiatric admissions requiring special care services when authorized

Substance use

Blue Cross reimburses Suboxone, Zubsolv, and their generics for the treatment of opioid addiction. Please refer to the medical policy link of the related policies section for additional information.

Methadone

- Blue Cross reimburses methadone under H0020.

- H0020 is described as "Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)." It includes, but is not limited to:
  - Physician time, nursing time, the cost of methadone and administration, including automated equipment and take-home doses, toxicology and lab fees, patient care monitors, and the cost of security.
  - It also covers services such as triage and assessment, both pre- and post-, take-home medication reviews and monitoring, patient education, referrals to primary care practitioners, emergency rooms and emergency service programs, emergency crisis management, services to pregnant women, TB risk assessment, transfers and guest dosing for other clinics, transcription of physician orders and data entry into electronic health records, coordination of care and post-discharge care for patients leaving the hospital, and DPH surveillance reporting on communicable diseases, the ordering and storing of methadone, hazardous waste disposal, and the provision of medical supplies.

Drug testing
The total number of drug tests related to any diagnosis category shall not exceed 20 tests (presumptive and/or confirmatory) per member, per 365 days. For members requiring additional services, please refer to the Appeals and Resubmissions page on Provider Central. See our Drug Testing payment policy for additional information.

Blue Cross does not reimburse:
- Environmental intervention
- Online services
- Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist the patient

General reimbursement information:
- Blue Cross considers virtual reality therapy and technology as inclusive to psychotherapy and not separately reimbursable
- Reimbursement rates for services delivered to members receiving care in an acute outpatient hospital setting are global, covering both the facility and professional services
  - No additional professional payment will be reimbursed to the facility or any other professional provider for commercial claims
  - Medicare Advantage claims follow CMS reimbursement guidelines
- Medication assisted treatment reimbursement is included in the emergency department rate and not reimbursed separately

Billing information

The list of codes below is included for *informational purposes only*. This may not be a complete list of all the codes related to this service. Whether or not a code is listed here does not guarantee coverage or reimbursement.

Specific billing guidelines for Intensive Community-Based Treatment (ICBT) services:
The HK modifier must be reported in the primary modifier field. You do not need to report the license modifier when submitting claims for these services.

Expedited Psychiatric Inpatient Admission (EPIA) services
When notifying Blue Cross of an EPIA admission, the admitting hospital may request individual consideration/clinical review of the requested admission and notify us that additional "specialing" services are necessary. Once the inpatient admission is approved, the hospital should bill for services rendered through standard coding practices. The hospital will be paid at 175 percent of their contracted inpatient rate. Standard payment policy rules apply for ancillary services billed within an inpatient admission.

Code	Service description	Comments
Revenue codes		
0113, 0114, 0116	Room and board - Private	May be used to report expedited psychiatric admissions requiring special care services
0910-0919	Behavioral health treatment/services	Bill with HCPCS describing the service provided
CPT/HCPCS codes		

Code	Service description	Comments
90785	Interactive complexity (add on code)	Must be reported with a primary service code
90791	Psychiatric diagnostic evaluation	May be used to report expedited psychiatric admissions requiring special care services
90792	Psychiatric diagnostic evaluation with medical services	May be used to report expedited psychiatric admissions requiring special care services
90832	Psychotherapy, 30 minutes with patient or family member	
90833	Psychotherapy, 30 minutes with patient or family member with an evaluation and management services	Must be reported with primary E/M service code
90834	Psychotherapy, 45 minutes with patient or family member	
90836	Psychotherapy, 45 minutes with patient or family member with an evaluation and management services	Must be reported with primary E/M service code
90837	Psychotherapy, 60 minutes with patient or family member	
90838	Psychotherapy, 60 minutes with patient or family member with an evaluation and management services	Must be reported with primary E/M service code
90839	Psychotherapy for crisis, first 60 minutes	
90840	Psychotherapy for crisis, each additional 30 minutes (add on code)	Must be reported with primary service code
90846	Family psychotherapy (without the patient present)	
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)	
90849	Multiple-family group psychotherapy	
90853	Group psychotherapy (other than of a multiple-family group)	
90867	Therapeutic repetitive magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management	
90868	Subsequent delivery and management, per session	
90869	Subsequent motor threshold re-determination with delivery and management	
90870	Electroconvulsive therapy	
90882	Environmental intervention for medical management	Not reimbursed
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	Not reimbursed
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour	Bill services on date service was performed
96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (list separately in addition to code for primary procedure)	Must be billed with primary service code Bill services on date(s) service was performed
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour	Bill services on date(s) service was performed
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional,	Must be billed with the primary service

Code	Service description	Comments
	both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (list separately in addition to code for primary procedure)	
96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	Bill services on date(s) service was performed
96131	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (list separately in addition to code for primary procedure)	Must be billed with the primary service
96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	Bill services on date(s) service was performed
96133	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (list separately in addition to code for primary procedure)	Must be billed with the primary service
96136 - 96139	Psychological or neuropsychological test administration and scoring	Bill services on date(s) service was performed Add on code must be billed with primary service code
96202	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes	Not reimbursed
96203	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); each additional 15 minutes	Not reimbursed
96365-96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis	Use to administer IV Ketamine Not separately reimbursed with an E/M
98970	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	Not reimbursed
98971	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	

Code	Service description	Comments
98972	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	
99202 - 99215	New or established patient, office or outpatient visits	May be used to report some psychiatric services when appropriate, or reported for treatment of psychiatric conditions, rather than the psychiatric services codes when appropriate
99304-99316	Initial, subsequent, and discharge nursing facility care per day	
99341-99342 99344-99350	Home or residence visits	
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	Not reimbursed
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	Not reimbursed
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	Not reimbursed
99446-99449	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional	Effective for dates of service on or after November 1, 2022: • Reimbursable for mental health providers only • Excludes FEP • Acute care hospitals and mental health facilities that bill on a UB-04 form, must bill these codes with professional mental health revenue code 961
99451-99452	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a written report to the patient's treating/requesting physician or other qualified health care professional	
99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team	
99492 – 99494 G2214	Psychiatric collaborative care management	
G0323	Care management services for behavioral health conditions, at least 20 minutes of clinical psychologist or clinical social worker time, per calendar month (these services include the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, coordination with and/or referral to physicians and practitioners who are authorized by Medicare to prescribe	Reimbursed once per calendar month

Code	Service description	Comments
	medications and furnish E/M services, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team)	
G0516 – G0518	Non-biodegradable drug delivery implant	Bill for administration of HCPCS J0570
G1028	Take-home supply of nasal naloxone; 2-pack of 8mg per 0.1 ml nasal spray (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure	Reimbursed for Medicare Advantage only Must be billed with primary service code
G2067	Medication assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled opioid treatment program)	Reimbursed for Medicare Advantage only
G2068	Medication assisted treatment, buprenorphine (oral); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program)	Reimbursed for Medicare Advantage only
G2069	Medication assisted treatment, buprenorphine (injectable); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program)	Reimbursed for Medicare Advantage only
G2070	Medication assisted treatment, buprenorphine (implant insertion); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program)	Reimbursed for Medicare Advantage only
G2071	Medication assisted treatment, buprenorphine (implant removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program)	Reimbursed for Medicare Advantage only
G2072	Medication assisted treatment, buprenorphine (implant insertion and removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program)	Reimbursed for Medicare Advantage only
G2073	Medication assisted treatment, naltrexone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program)	Reimbursed for Medicare Advantage only
G2074	Medication assisted treatment, weekly bundle not including the drug, including substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program)	Reimbursed for Medicare Advantage only
G2075	Medication assisted treatment, medication not otherwise specified; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled opioid treatment program)	Reimbursed for Medicare Advantage only
G2076	Intake activities, including initial medical examination that is a complete, fully documented physical evaluation and initial assessment by a program physician or a primary care physician, or	Reimbursed for Medicare Advantage only

Code	Service description	Comments
	an authorized healthcare professional under the supervision of a program physician qualified personnel that includes preparation of a treatment plan that includes the patient's short-term goals and the tasks the patient must perform to complete the short-term goals; the patient's requirements for education, vocational rehabilitation, and employment; and the medical, psycho- social, economic, legal, or other supportive services that a patient needs, conducted by qualified personnel (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure	Must be billed with primary service code
G2077	Periodic assessment; assessing periodically by qualified personnel to determine the most appropriate combination of services and treatment (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure	Reimbursed for Medicare Advantage only Must be billed with primary service code
G2078	Take-home supply of methadone; up to 7 additional day supply (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure	Reimbursed for Medicare Advantage only Must be billed with primary service code
G2079	Take-home supply of buprenorphine (oral); up to 7 additional day supply (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure	Reimbursed for Medicare Advantage only Must be billed with primary service code
G2080	Each additional 30 minutes of counseling in a week of medication assisted treatment, (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure	Reimbursed for Medicare Advantage only Must be billed with primary service code
G2082	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of up to 56 mg of esketamine nasal self-administration, includes 2 hours post-administration observation	When reimbursed, the payment includes all E/M time associated with the visit and the provision of esketamine
G2083	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of greater than 56 mg esketamine nasal self-administration, includes 2 hours post-administration observation	
G2086	Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month	
G2087	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month	
G2088	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure)	Must be billed with primary service code
G2215	Take-home supply of nasal naloxone (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure	Reimbursed for Medicare Advantage only Must be billed with primary service code
G2216	Take-home supply of injectable naloxone (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure	Reimbursed for Med Advantage only Must be billed with primary service code

Code	Service description	Comments
H0023	Behavioral health outreach service (planned approach to reach a targeted population)	• Use to bill for community-based services for family support and training • Bill with HK modifier • Reimbursed once per calendar month
H0025	Behavioral health prevention education service (Family Support and Training)	• Use to bill for community-based services for family support and training • Bill with HK modifier
H0040	Assertive community treatment program, per diem (In-home behavioral services))	• Use to bill for community-based in-home behavioral health services. Includes: o Behavior management monitoring o Behavior management therapy • Bill with HK modifier
H0046	Mental health services, not otherwise specified	• May be used to report expedited psychiatric admissions requiring special care services • Use to bill for community-based therapeutic mentoring • Must bill with HK modifier
H2020	Therapeutic behavioral services, per diem (In-home therapy)	• Use to bill for community-based in-home therapy treatment. Includes: o Therapeutic clinical intervention or ongoing training as well as support • Bill with HK modifier
J0570	Buprenorphine implant, 74.2 mg	
T1002	Rn services, up to 15 minutes	May be used to report expedited psychiatric admissions requiring special care services
Modifiers		
HK	Therapeutic behavioral services	• Report in primary modifier field • Use modifier to indicate intensive community-based treatment services. Includes: o Intensive care coordination o In-home therapy o In-home behavioral services o Family support and training o Therapeutic monitoring

When submitting claims, report all services with:

- Up-to-date industry-standard procedure and diagnosis codes, and
- Modifiers that affect payment in the first modifier field, followed by informational modifiers

Related policies

Note: Log into Provider Central before clicking Payment Policy links.

Autism
Community Mental Health Centers
CPT and HCPCS Modifiers
Drug Testing
Evaluation and Management
General Coding and Billing
Non-Reimbursable Services
Telehealth (Telemedicine) - Mental Health
Medical policies

Policy update history

10/27/2014	Documentation of existing policy; guidance for reporting psychotherapy services whose duration exceeds 52 minutes
07/29/2015	Template update; annual review; inclusion of information on access to care for managed care members
10/01/2015	Inclusion of telemedicine payment policy link to the "Related Policies" section
10/30/2015	Inclusion of information on reimbursement for services delivered to members receiving care in an acute outpatient hospital setting
09/30/2016	Updated references to the drug testing payment policy and Medical Policy # 674: Drug Testing in Pain Management and Substance Abuse Treatment Settings to reflect the name change of the polices
01/01/2017	Annual review; template update; inclusion of information on methadone reimbursement guidelines; inclusion of information on prior notification guidelines for one-hour psychotherapy services
01/01/2018	Removal of guidance for reporting psychotherapy services whose duration exceeds 52 minutes
02/06/2018	Removal of references to retired medical policy
07/26/2018	Replaced references of drug abuse with drug use
09/30/2018	Inclusion of virtual reality therapy reimbursement information
12/31/2018	Annual review expanded documentation of existing reimbursed and non-reimbursed services; inclusion MAT and coding grid and revenue codes, outpatient facility reimbursement edits for clarity
07/01/2019	Update to include reimbursement and coding information for Intensive Community-Based Treatment (ICBT) services; added community mental health centers to related policies
09/30/2019	Added reimbursement for expedited psychiatric special services, edits for clarity under drug testing.
12/31/2019	Annual coding update; deleted 99444, added 99421-99423, 98970-98972, G2061-G2063, G2067-G2080, G2086-G2088
06/30/2020	Added reimbursement information for Esketamine and IV Ketamine
11/01/2020	Updated with info for intensive community-based treatment (ICBT) services for family support and training and therapeutic mentoring
12/31/2020	Annual review, and annual coding update; updated range to remove end dated code 99201, added G2214, G2215, G2216, removed G2082 and G2083 codes from coding grid, edits for clarity, added EM as related policy
01/11/2021	Updated to remove end dated codes G2061, G2062, G2063
12/31/2021	Changed document name from Behavioral Health and Substance Use Disorders to Mental Health and Substance Use Disorders; annual coding update; added G1028 for MedAdv only; removed telephone from not reimbursed; included additional information for expedited psychiatric inpatient admissions
11/01/2022	Updated to include reimbursement and billing information on Mental Health services eligible for TH reimbursement effective for DOS on or after 11/1/2022 for 99446-99449 and 99451-99452. Acute care and mental health facilities must bill these services with a professional mental health revenue code 961
12/31/2022	Annual coding update, added new codes 96202, 96203 and G0323, updated revised codes 99446 to 99451, remove deleted codes 99318, 99324 to 99337; added code ranges for home/residence and nursing facility

3/31/2023	Annual review, added comments for 96202 and 96203
6/30/2023	Annual review, no updates

Payment policies are intended to help providers obtain Blue Cross Blue Shield of Massachusetts' payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy development takes into consideration a variety of factors, including: the terms of the participating provider's contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

MPC_110315-1P-8

EXHIBIT B

Blue Cross Blue Shield of Massachusetts
Fee Schedule for Psychiatrists
Effective January 1, 2015

Procedure Code	Narrative		Non-Facility Fee	Facility Fee **
90785	PSYTX COMPLEX INTERACTIVE		$17.02	$17.02
90791	PSYCH DIAGNOSTIC EVALUATION	*	$159.34	$153.60
90792	PSYCH DIAG EVAL W/MED SRVCS	*	$171.75	$166.02
90832	PSYTX PT&/FAMILY 30 MINUTES	*	$76.71	$75.75
90833	PSYTX PT&/FAM W/E&M 30 MIN	*	$78.62	$78.14
90834	PSYTX PT&/FAMILY 45 MINUTES	*	$101.64	$101.16
90836	PSYTX PT&/FAM W/E&M 45 MIN	*	$99.54	$98.58
90837	PSYTX PT&/FAMILY 60 MINUTES	*	$152.17	$151.21
90838	PSYTX PT&/FAM W/E&M 60 MIN	*	$131.35	$130.40
90839	PSYTX CRISIS INITIAL 60 MIN	*	$159.07	$157.63
90840	PSYTX CRISIS EA ADDL 30 MIN	*	$76.23	$75.75
90846	FAMILY PSYTX W/O PATIENT	*	$123.52	$122.56
90847	FAMILY PSYTX W/PATIENT	*	$127.24	$126.28
90849	MULTIPLE FAMILY GROUP PSYTX	*	$41.91	$37.13
90853	GROUP PSYCHOTHERAPY	*	$31.39	$30.44
90867	TCRANIAL MAGN STIM TX PLAN	*	$489.70	$214.75
90868	TCRANIAL MAGN STIM TX DELI	*	$243.81	$29.50
90869	TCRAN MAGN STIM REDETEMINE	*	$613.16	$139.18
90870	ELECTROCONVULSIVE THERAPY	*	$221.50	$133.56
96101	PSYCHO TESTING BY PSYCH/PHYS	*	$95.95	$94.99
96102	PSYCHO TESTING BY TECHNICIAN	*	$84.97	$28.09
96103	PSYCHO TESTING ADMIN BY COMP	*	$33.77	$32.34
96110	DEVELOPMENTAL SCREEN		$10.81	$10.81
96116	NEUROBEHAVIORAL STATUS EXAM	*	$114.03	$105.90
96118	NEUROPSYCH TST BY PSYCH/PHYS	*	$120.32	$94.51
96119	NEUROPSYCH TESTING BY TEC	*	$105.13	$28.18
96120	NEUROPSYCH TST ADMIN W/COMP	*	$60.54	$31.38
96150	ASSESS HLTH/BEHAVE INIT	*	$25.60	$25.12
96151	ASSESS HLTH/BEHAVE SUBSEQ	*	$24.76	$24.28
96152	INTERVENE HLTH/BEHAVE INDIV	*	$23.44	$22.96
96153	INTERVENE HLTH/BEHAVE GROUP		$5.45	$5.45
96154	INTERV HLTH/BEHAV FAM W/PT	*	$23.02	$22.54
96155	INTERV HLTH/BEHAV FAM NO PT		$27.48	$27.48
99201	OFFICE/OUTPATIENT VISIT NEW	*	$54.31	$31.84
99202	OFFICE/OUTPATIENT VISIT NEW	*	$92.73	$60.70
99203	OFFICE/OUTPATIENT VISIT NEW	*	$133.70	$92.11
99204	OFFICE/OUTPATIENT VISIT NEW	*	$203.60	$157.72
99205	OFFICE/OUTPATIENT VISIT NEW	*	$253.06	$203.83
99211	OFFICE/OUTPATIENT VISIT EST	*	$25.54	$11.20
99212	OFFICE/OUTPATIENT VISIT EST	*	$54.79	$30.41
99213	OFFICE/OUTPATIENT VISIT EST	*	$90.58	$61.90
99214	OFFICE/OUTPATIENT VISIT EST	*	$133.32	$95.08
99215	OFFICE/OUTPATIENT VISIT EST	*	$177.98	$134.01
99221	INITIAL HOSPITAL CARE		$121.93	$121.93
99222	INITIAL HOSPITAL CARE		$165.94	$165.94
99223	INITIAL HOSPITAL CARE		$244.87	$244.87
99231	SUBSEQUENT HOSPITAL CARE		$47.24	$47.24
99232	SUBSEQUENT HOSPITAL CARE		$87.01	$87.01
99233	SUBSEQUENT HOSPITAL CARE		$125.46	$125.46
99238	HOSPITAL DISCHARGE DAY		$88.31	$88.31
99239	HOSPITAL DISCHARGE DAY		$130.34	$130.34
99281	EMERGENCY DEPT VISIT		$29.16	$29.16
99282	EMERGENCY DEPT VISIT		$57.11	$57.11
99283	EMERGENCY DEPT VISIT		$85.09	$85.09
99284	EMERGENCY DEPT VISIT		$161.86	$161.86
99285	EMERGENCY DEPT VISIT		$238.04	$238.04
99304	NURSING FACILITY CARE INIT		$112.83	$112.83
99305	NURSING FACILITY CARE INIT		$160.65	$160.65
99306	NURSING FACILITY CARE INIT		$203.30	$203.30

*Service subject to practice expense differential.
**The facility fee shall apply to services provided at an inpatient or outpatient hospital, a skilled nursing facility, or a free-standing ambulatory surgery center.

Blue Cross Blue Shield of Massachusetts
Fee Schedule for Psychiatrists
Effective January 1, 2015

Procedure Code	Narrative		Non-Facility Fee	Facility Fee **
99307	NURSING FAC CARE SUBSEQ		$54.60	$54.60
99308	NURSING FAC CARE SUBSEQ		$84.23	$84.23
99309	NURSING FAC CARE SUBSEQ		$110.94	$110.94
99310	NURSING FAC CARE SUBSEQ		$164.64	$164.64
99324	DOMICIL/R-HOME VISIT NEW PAT		$67.41	$67.41
99325	DOMICIL/R-HOME VISIT NEW PAT		$97.83	$97.83
99326	DOMICIL/R-HOME VISIT NEW PAT		$168.86	$168.86
99334	DOMICIL/R-HOME VISIT EST PAT		$73.75	$73.75
99335	DOMICIL/R-HOME VISIT EST PAT		$115.32	$115.32
99336	DOMICIL/R-HOME VISIT EST PAT		$162.57	$162.57
99408	AUDIT/DAST 15-30 MIN	*	$42.81	$40.42
99409	AUDIT/DAST OVER 30 MIN	*	$83.23	$80.84
G0431	RX SCR MX RX CLASS HI CMPLX PT ENC		$67.74	$67.74
G0434	DRUG SCR NOT CGC: ANY NUMBER PT ENC		$13.55	$13.55
H0031	MENTAL HEALTH ASSESS NON-PHYSICIAN		$101.64	$101.64
H2012	BEHAVIORAL HEALTH DAY TX PER HOUR		$101.64	$101.64
H2019	THERAPEUTIC BEHAVIORAL SRVC 15 MIN		$12.71	$12.71

*Service subject to practice expense differential.
**The facility fee shall apply to services provided at an inpatient or outpatient hospital, a skilled nursing facility, or a free-standing ambulatory surgery center.