James E. Cecchi
Lindsey H. Taylor
CARELLA, BYRNE, CECCHI,
OLSTEIN, BRODY & AGNELLO, P.C.
5 Becker Farm Road
Roseland, New Jersey 07068
(973) 994-1700

Vincent N. Buttaci
John W. Leardi
Paul D. Werner
BUTTACI & LEARDI, LLC
103 Carnegie Center, Suite 101
Princeton, New Jersey 08540
(609) 799-5150

D. Brian Hufford
Robert J. Axelrod
Susan J. Weiswasser
POMERANTZ HAUDEK
GROSSMAN & GROSS LLP
100 Park Avenue
New York, New York 10017
(212) 661-1100

Kimberly A. Driggers
BROOKS, LeBOEUF, BENNETT,
FOSTER & GWARTNEY, P.A.
909 East Park Avenue
Tallahassee, FL 32301
(850) 222-2000

Co-Lead Counsel for Plaintiffs and the Putative Class

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

PREMIER HEALTH CENTER, P.C., and JUDSON G. SPRANDEL, II, D.C., on their own behalf and on behalf of all others similarly situated, and the OHIO STATE CHIROPRACTIC ASSOCIATION, in a representational capacity on behalf of its members, Plaintiffs, v. UNITEDHEALTH GROUP, UNITED HEALTHCARE SERVICES, INC., HEALTH NET OF THE NORTHEAST, INC., and HEALTH NET OF NEW YORK, INC., Defendants.	Civil Action No.: **COMPLAINT**

Plaintiff Premier Health Center P.C. ("Premier Health"), is a New Jersey professional corporation located at 385 Prospect Avenue, Hackensack, New Jersey 07601. It is wholly-owned

by Phillip Kim, D.C. ("Kim"). Plaintiff Judson G. Sprandel, II, D.C. ("Sprandel"), is a licensed Doctor of Chiropractic who practices at 1412 Cleveland Avenue, N.W., Canton, Ohio 44703. Plaintiff Ohio State Chiropractic Association ("OSCA") is a membership organization which serves the interests of chiropractic physicians practicing in the State of Ohio. To the best of Plaintiffs' knowledge, information and belief, formed after an inquiry reasonable under the circumstances, for their Class Action Complaint (hereinafter "Complaint"), Plaintiffs assert the following against Defendants UnitedHealth Group, United HealthCare Services, Inc., Health Net of the Northeast, Inc., and Health Net of New York, Inc. (collectively, "Defendants" or "United," except where the latter two Defendants are being discussed separately, in which case they are referred to jointly as "Health Net").

INTRODUCTION

1. Plaintiffs bring this action against Defendants under the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001, *et seq.* ("ERISA").

2. Plaintiffs Premier Health and Sprandel ("Individual Plaintiffs") and the members of the putative Class, as defined below, are health care providers who have provided health care services to members of health care plans insured or administered by United ("United Insureds"), and who have been paid by United for providing such services through the issuance of benefits under the terms and conditions of the United Insureds' health care plans ("United Plans"). Plaintiff OSCA is a membership organization that serves the interests of chiropractic physicians in the State of Ohio. It brings this action in a representational capacity on behalf of its members. As alleged herein, United engaged in post-payment audits of the benefit payments made to the Individual Plaintiffs and other members of the Class and subsequently determined that it had erroneously made overpayments that it then demanded be repaid. It then took steps to coerce the Individual Plaintiffs and other Class members to return the alleged overpayments, including by

withholding payments from new and unrelated services and applying them to the alleged debt, or by filing invalid lawsuits seeking to compel repayment.

3. Many of the United Plans at issue are provided through private employers. As a result, they are governed by ERISA, which establishes strict rules and procedures that United or other entities that administer ERISA plans must comply with. Among other things, ERISA sets forth specific steps that must be followed when an insurer such as United makes an "adverse benefit determination" by denying or reducing benefits, including by providing a "full and fair review" of the decision. By making a retroactive determination that a previously paid benefit was, in fact, paid improperly, an insurer makes an adverse benefit determination under ERISA. As detailed herein, United has violated ERISA by making its retroactive adverse benefit determinations without complying with ERISA requirements.

THE PARTIES

Plaintiffs

4. Premier Health operates a multidisciplinary health care clinic that provides professional chiropractic and physical therapy health care services to various patients, many of whom are United Insureds. Premier Health is an out-of-network ("ONET") health care provider, which means that it never signed an agreement with Defendants to accept discounted rates in exchange for having United Insureds directed to it. Rather, it provides services to patients who choose to come to it, and then, pursuant to assignments that are signed by its patients, bills to and receives benefit payments directly from United on behalf of the United Insured patients.

5. The standard "Assignment of Benefits Form" that Premier Health has its patients sign states:

> I hereby instruct and direct [United or Health Net] Insurance Company to pay by check made out and mailed out to: Premier Health Center, P.C., 385 Prospect Ave., 1Fl., Hackensack, NJ 07601, Or

> If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows: [to same address]
>
> For the professional or expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

Pursuant to this assignment, Plaintiff has standing to pursue claims under ERISA.

6. Dr. Sprandel is a Doctor of Chiropractic who also provides services to numerous United Insureds. He is an in-network provider with United, which means that he has agreed to accepted discounted rates from United for providing Covered Services to United Insureds (as defined in the United Plans). Dr. Sprandel has become an in-network provider in order to gain better access to United Insureds as patients.

7. As does Premier Health, Dr. Sprandel has his patients execute written assignments, as a matter of course, in which they agree that he may bill and receive payments directly from United. Thus, he, too, has standing to pursue ERISA claims. Further Dr. Sprandel's patients affirm that they remain financially liable for any portion of the bill that is deemed not to be medically necessary or otherwise not a Covered Service.

8. The OSCA is a chiropractic association based in Columbus, Ohio. Dr. Sprandel is a member of the OSCA and its former President. As of the end of 2010, the OSCA's membership consisted of more than 800 chiropractic physicians residing and practicing in the State of Ohio. The OSCA's declared mission is to "empower Ohio chiropractic physicians as the preferred choice for health care needs, specializing in spinal care, neuromuscular care and/or nervous system function; and [to educate] the general public and policymakers on the importance of chiropractic in reaching one's fully human potential." Further, the OSCA's Mission Statement

is as follows:

> Our mission is to promote the science, philosophy and art of the chiropractic profession by advocating the highest standard of ethics in practice; by working united to advance the profession; by developing close cooperation among the doctors within the association for the welfare of all Doctors of Chiropractic and the public we serve; and by promoting desirable relationships with other entities for the benefit of the chiropractic profession.

The OSCA brings this action in an associational capacity on behalf of its members, many of whom have suffered improper audits, repayment demands and recoupments from Defendants.

Defendants

9. Defendant UnitedHealth Group is a corporation organized and existing under and pursuant to the laws of Minnesota which issues and administers health care plans around the country through its various wholly owned and controlled subsidiaries, including Defendant United HealthCare Services, Inc., Defendants Health Net of the Northeast, Inc., is a wholly-owned subsidiary of Health Net, Inc., a California based health insurance company. The assets of Health Net of the Northeast, Inc., including its various licensed subsidiaries, such as Health Net of New York, Inc., were acquired by UnitedHealth Group in December 2009, such that United now wholly owns and controls the Health Net of New York, Inc. United and, acting in their own name, the Health Net Defendants, engaged in numerous post-payment audits and have improperly recouped or otherwise sought to recover payments from many Providers, including Plaintiffs, in violation of ERISA.

10. Due to the manner in which Defendants function with respect to their United Plans, they are all functional ERISA fiduciaries and, as such, must comply with fiduciary standards. Moreover, in making coverage determinations relating to their United Insureds, Defendants must comply with the terms and conditions of the applicable health care plans and otherwise must comply with ERISA and its underlying regulations.

JURISDICTION AND VENUE

11. Defendants' actions in administering employer-sponsored health care plans, including determining reimbursements for Providers who supply health care services to United Insureds pursuant to the terms and conditions of the health care plans, are governed by ERISA, 29 U.S.C. § 1001, *et seq.* Plaintiffs assert subject matter jurisdiction under 28 U.S.C. § 1331 (federal question jurisdiction), 29 U.S.C. § 1132(e) (ERISA).

12. Venue is appropriate in this District for Plaintiffs' claims under 28 U.S.C. § 1391 and 29 U.S.C. § 1132(e)(2) because Plaintiff Premier Health resides and operates here, material portions of the improper repayment demands that are the subject of this lawsuit occurred here, and Defendants are authorized to do business here, either directly or through wholly owned and controlled subsidiaries.

THE EXPERIENCE OF PLAINTIFF PREMIER HEALTH WITH UNITED HEALTH PLANS

Health Net

13. On or about January 6, 2010, Plaintiff Premier Health received a series of letters from Health Net, through Health Net of New York, Inc. Recovery Unit, notifying Premier Health of a purported overpayment of previously paid benefits. The letter stated:

> We recently determined that the claim referenced above was overpaid by [a specified amount which differed for each letter] for the reason listed at the bottom of this notice. Additional, there may be interest if indicated above.
>
> You may elect to refund the amount paid incorrectly. If we do not receive your payment within 30 calendar days from the date of this letter, we will deduct the overpayment amount from future claim payments.
>
> Please send a refund check for [the specified amount] within 30 calendar days to the address listed below. A copy of this letter must accompany your payment. We have included a postage paid envelope for your convenience. . . .
>
> If you believe the overpayment refund request is incorrect, you have 30 calendar days from the date of this letter to send written documentation of your dispute to:

> Provider Service Unit, 1 Far Mill Crossing, P.O. Box 904, Shelton, CT 06484 or call . . .

14. At the bottom of the letter, Health Net listed the following as "Reasons" for the repayment demand: "Adjustment made to prior payment; New information received by plan, member not eligible on the date of service." In total, Health Net demanded that Premier Health repay approximately $4,500 for services provided to a United Insured primarily in June 2009.

15. On January 25, 2010, through its agent, Precision Billing & Consulting Services, LLC ("Precision Billing"), Premier Health submitted a first level appeal to Health Net's repayment demand in which it specifically stated: "I am contesting this [repayment] request and the money may not be deducted without a hearing." The letter then detailed the information that was necessary to allow the appeal to proceed:

> I must respectfully decline your request until the following documentation has been presented to establish your entitlement to the refund. Our records indicate, and your payment confirms, that the patient was insured under your health care plan and covered for services rendered at the time of treatment.
>
> Therefore, I must have documentation to support your right to a reversal of payment. I will carefully review these documents to determine the appropriateness of this request. I will require:
>
> 1. A copy of the claim.
> 2. A copy of the canceled check.
> 3. A clearly stated reason for this reversal of payment.
> 4. An explanation as to why the claim was originally considered acceptable and is now denied.
> 5. The statute of limitations in regard to the refunds.
> 6. A copy of the appropriate section of your contract stating your entitlement of this action.
>
> I am entitled to this information in a timely manner. However, your demand of payment within 30 days is unrealistic. You will need time to gather the information and I will equally need time to review it. Therefore your threat of deducting the monies from my future claim payments is inappropriate,

> unprofessional and illegal!
>
> Upon arrival of the fore-mentioned documentation I will carefully review it and determine if I feel a refund is appropriate.
>
> Be advised that I DO NOT authorize an extraction from future payments to cover this.

16. In the letter, Premier Health then cited several court decisions in which it was established that the risk of loss arising from an erroneous payment by an insurer to a health care provider rests with the insurance company, such that recoupment of such payments would be improper.

17. Health Net did not formally respond to the appeal, but in subsequent telephone calls, Health Net represented to Premier Health that Health Net would not consider the appeal and that it was therefore effectively denied. By February 26, 2010, Health Net had begun to recoup the alleged overpayments by withholding sums from payments otherwise due and owing to Premier Health for services provided to United Insureds.

18. In an email to Premier Health dated March 16, 2010, Health Net confirmed the recoupments had begun, stating:

> Below is a breakdown of all claims retracted, showing if recouped or still open. Again if the Member can get her coverage updated than all of these claims will be reprocessed. If she cannot get coverage retro-activated than she will be responsible for payment to you in full on these claims.

19. The email summarized that a total of $3,084 had been recouped, by withholding payments for unrelated claims that were otherwise payment benefits, with an additional $1,382 "on hold." The email ended by stating: "There is nothing further I can do to resolve this issue." Health Net has proceeded to recoup funds from Premier Health in an amount exceeding that which it claimed to have been overpaid.

20. Prior to recouping the funds, Health Net failed to offer or provide Premier Health

with a "full and fair review" of the retroactive adverse benefit determination which served as the basis for its repayment demand. For this and other reasons, Health Net violated ERISA.

United

21. Among the services Dr. Kim, on behalf of Premier Health, provides to his patients are Manipulation under Anesthesia ("MUA"), where a provider places a patient under anesthesia before providing spinal manipulation services, and Nerve Conduction Studies ("NCV"), which are used to find damage to the peripheral nervous system and to assist in the diagnosis of and treatment for nerve disorders. Dr. Kim has provided these treatments to United Insureds for years; these services have been reimbursed as Covered Services under the patients' health care plans throughout.

22. At some point beginning as early as 2006 for MUA and 2008 for NCV, United changed its policy and began to deny coverage for such services. Premier Health appealed those denials and exhausted all administrative remedies. Premier Health subsequently sued United in state court in New Jersey seeking coverage for the denied benefits on behalf of a number of United Insureds for whom it provided these and other health care services.

23. On November 30, 2010, United filed its Second Amended Answer to Amended Complaint, Defenses and Amended Counterclaim ("United Counterclaim") to Premier Health's state law complaint. In its counterclaim, United asserts that it "was and is the administrator and/or insurer of major medical and hospitalization plans sponsored by employers and offered to their employees throughout the United States, including New Jersey," defining them collectively as the "Health Plans," adding that "[m]any of these Health Plans . . . were and are employee welfare benefit plans governed by ERISA." United Counterclaim, ¶ 5.

24. United proceeds to assert a right to repayment for previously paid MUA and NCV

payments to Dr. Kim, on the basis that they were not Covered Services under the applicable Health Plans, stating:

> Phillip Kim, D.C. and Plaintiff have been erroneously reimbursed for MUA services, which are not covered under the [Health] Plans. Plaintiff has submitted under Phillip Kim, D.C.'s name for serial MUA procedures, that are not covered services under The Plans, and which were performed on at least nine [United] participants.
>
> Phillip Kim, D.C. and Plaintiff have also been erroneously reimbursed for nerve conduction studies, which were not performed in conjunction with needle electromyography, and therefore are not covered services.

United Counterclaim, ¶¶ 20-21.

25. United then asserted that it was seeking overpayment of "no less than $498,000," representing the aggregate amount by which it purportedly had overpaid Premier Health for providing non-covered MUA and NCV services. In so doing, United made clear that it was asserting its claim as a remedy under ERISA, stating:

> Pursuant to 29 U.S.C. § 1132(a), with respect to the Health Plans governed by ERISA, [United] may bring a civil action to obtain "appropriate equitable relief" to redress violations of ERISA or the terms of an ERISA plan, or to enforce any provisions of ERISA or the terms of the ERISA plan.

Id. ¶ 31. Further, United asserted that any claims by Premier Health to challenge United's payment policies were preempted by ERISA: "Plaintiff's remedies for any act or omission of United are limited solely to those afforded by ERISA. *Id.* ¶ 5.

26. United is correct that ERISA governs a dispute over the alleged overpayment of health care benefits and related repayment demands made by insurers against providers. Its counterclaim, however, was improvidently filed as state courts do not have jurisdiction over the ERISA claims filed by United. Premier Health, therefore, be filed a motion to dismiss the Counterclaim.

27. In this action, Premier Health seeks to exercise its rights under ERISA, pursuant

to assignments it has received from its United Insured patients, to preclude United from seeking to enforce its repayment demands. Among other things, United cannot pursue a repayment demand, which constitutes a retroactive adverse benefit determination, without complying with ERISA's detailed procedural guidelines, including the requirement that United provide a "full and fair review" of its adverse benefit determinations.

THE EXPERIENCE OF PLAINTIFF SPRANDEL WITH UNITED HEALTH PLANS

28. In mid-2009, Dr. Sprandel received various requests for medical records from OptumHealth, a wholly-owned subsidiary of United, as part of an ongoing post-payment audit of benefits he had previously received for services provided to United Insureds. Dr. Sprandel complied with the requests and provided the records.

29. In August 2009, Dr. Sprandel received a series of formal "Refund Requests" from OptumHealth, sent under the letterhead of Johnson & Rountree, a collection agency retained by United for work on collecting alleged overpayments from providers. In these requests, OptumHealth identified the date of service, from 2008 or 2009, with the amount of overpayment identified. The following was listed as the "Overpayment Reason":

> Claim paid for a service not payable under OptumHealth Reimbursement Policy.
>
> Manual therapy (97140) must be documented as a distinct service not in the chiropractic manipulative treatment region and must meet the timed-service requirement as described in ANC Group UM Policy 474 and Reimbursement Policies 0045 & 0049. The following CPT codes are not supported by the documentation submitted. [Date of service]: 97149.

30. This was followed by a series of letters from OptumHealth in or around September 2009, in which it stated it had "recently performed a review of UnitedHealthcare paid claims" in which "it was determined the claim(s) . . . was/were paid incorrectly." After asking that a "refund check" be made out to UnitedHealthcare and sent to Johnson & Rountree, it

added: "If you believe these findings are in error, you have the right to appeal. If you want to appeal, you must do so within 30 days of receipt of this initial request by submitting, in writing, the reason for your appeal, any documentation, and supporting material to Johnson & Rountree . . ." Finally, it stated that "[i]f a response is not received, UnitedHealthcare may offset future payments by the refund amount requested."

31. By letter dated November 4, 2009, Dr. Sprandel submitted a formal appeal to United's repayment demand, stating:

> The purpose of this correspondence is to furnish proof that the services rendered to your insured, my patient, were reasonable necessary, and the billing codes for same are herein discussed for clarification purposes, and to remain adamant that no overpayment exists, the UCR rates of [United] have been applied by us, a plan provider for [United].

32. In the letter, Dr. Sprandel explained that he used CPT Code 97140 with modifier -59 to demonstrate that he was providing this service on a region unrelated to the area of chiropractic manipulative treatment that was therefore properly payable as a distinct service, as explained in the coding books identifying proper coding protocols: "[I]f the 97140 service is at a different region, the AMA approves its usage. For such encounters, the modifier -59 is appended to the 97140, and it signifies that a distinct procedure is being performed at other than the CMT treatment region."

33. United (through OptumHealth and Johnson & Rountree) denied the appeal by letter dated November 19, 2009, stating:

> Johnson & Rountree Premium, on behalf of ANC Group, Inc. ("OptumHealth Care Solutions"), previously contacted you regarding this incorrect payment and requested a refund. You filed a written appeal. After reviewing the documentation submitted, we find the overpayment refund request remains valid. The details of the decision(s) are explained on the attached list.
>
> Please make your refund check payable to UnitedHealthcare and mail the check along with a copy of this letter and attached list to Johnson & Rountree Premium, P.O. Box 203921, Houston, TX 77216-3921.

> If you believe this decision was made in error, please submit in writing the reasons for your continuing appeal, any documentation, and supporting material to Johnson & Rountree Premium, PO Box 2625, Del Mar, CA 92014.
>
> Your prompt attention to this matter is greatly appreciate. If a response is not received, UnitedHealthcare may offset future payments by the refund amount requested.

The list attached to the letter identified the amounts that were allegedly overpaid, with the statement: "A second audit of the originally submitted medical records has been completed. The overpayment determination that CPT code 97140 is not supported by the required documentation has been upheld."

34. Dr. Sprandel responded to this correspondence with a letter dated December 2, 2009, stating as follows:

> [S]ince the issue dispute is 97140-59 for services wherein trigger point compression was manually administered, we have consulted a billing specialist who recommended using code 97124-59, instead of 97140-59.
>
> Since the services have been paid, please note rebilling is for correction of code purposes only.

35. After resubmitting the bills with the revised code, Dr. Sprandel continued to receive reports from Johnson & Rountree asking for repayment. He therefore submitted further appeals, asking for back-up information supporting the pricing paid for the treatments and for the claim that the treatments provided were not Covered Services under the patients' health care plans. In one letter dated December 17, 2009, Dr. Sprandel stated:

> We have re-examined the 12-07-2009 corrected billing and find that HGFA [sic] billing was originally $51.00 for CPT code 97124. You will need to furnish the claimant/insureds SPD [summary plan description] to prove that CPT 97124 . . . is not a covered service.

36. In another letter of the same date, referring to continued repayment demands relating to CPT code 97140, Dr. Sprandel reiterated his demand for back-up information, including the patients' SPD and the "'audit' notes" relating to the repayment demand. In

requesting such information, Dr. Sprandel stated:

> We cannot simply "accept" your word – we must have proof of your assumptions and this will be the third time we have asked you for proof of price lists within this patient's SPD (Summary Plan Description), which is probably an ERISA matter, hence, there should be a printed SPD available to me as a provider. If this is an ERISA contract, you must furnish the SPD or face a fine of $100.00 per day for not furnishing the SPD on a timely basis.

37. Without responding to Dr. Sprandel's request for back-up information, United (through OptumHealth and Johnson & Rountree) issued new letters in January 2010, designated as "Appeal Resolution – Overpayment Still Exists," which simply repeated the same language from the November 19, 2009 letter, stating that the appeal had been denied and the overpayment remained due and owing. Accompanying these letters were the same charts reflecting the overpayment demand, stating:

> A third audit of the originally submitted medical records has been completed. The overpayment determination that CPT code 97140 is not supported by the required documentation has been upheld.

38. Dr. Sprandel has continued to receive repeated refund requests from Johnson & Rountree on behalf of United, forcing Dr. Sprandel and his staff to waste valuable time and energy responding to such requests and filing repeated and futile appeals. Each and every time, United (through Johnson & Rountree) has denied the appeals, while ignoring the requests for back-up information and related documents. Through this action, Dr. Sprandel seeks to exercise his rights under ERISA, pursuant to assignments he has received from his patients insured by United, to preclude United from seeking to enforce its repayment demands. Among other things, United cannot pursue a repayment demand, which constitutes a retroactive adverse benefit determination, without complying with ERISA's detailed procedural guidelines, including the requirement that United provide a "full and fair review" of its adverse benefit determinations.

UNITED'S ERISA VIOLATIONS

39. Due to the role United played in administering the United Plans that provided the insurance to the patients whose claims were subsequently determined to be overpaid, including making coverage and benefit decisions and deciding appeals, it acted as a fiduciary under ERISA. Under ERISA, United cannot deny coverage for such services unless the applicable health care plan expressly includes an exclusion specifying that such services are not covered benefits.

40. Under ERISA, United is required, among other things, to comply with the terms and conditions of its health care plans; to accord its United Subscribers or their providers an opportunity to obtain a "full and fair review" of any denied or reduced reimbursements; and to make appropriate and non-misleading disclosures to United Subscribers or their providers. Such disclosures include accurately setting forth plan terms; explaining the specific reasons why a claim is denied and the internal rules and evidence that underlie such determinations; disclosing the basis for its interpretation of plan terms; and providing appropriate data and documentation concerning its coverage decisions.

41. In offering and administering its health care plans, United further assumes the role of "Plan Administrator," as that term is defined under ERISA, in that it interprets and applies the plan terms, makes all coverage decisions, and provides for payment to members and/or their providers. As the acting Plan Administrator, United also assumes various obligations specified under ERISA. These obligations include providing its members with a Summary Plan Description ("SPD"), a document designed to describe in layperson's language the material terms, conditions and limitations of the health care plan. The full details of the plan, which are summarized in the SPD, are contained in the Evidence of Coverage ("EOC") that governs each

member's health care plan.

42. United is also obligated under ERISA to make its coverage determinations in a manner consistent with the disclosures contained in the SPD. To the extent there is a disparity or conflict between the SPD and the EOC, the SPD governs, so long as the member benefits from the application of the SPD. If the employer, rather than United, is deemed to be the Plan Administrator, United remains responsible for ensuring that the SPD complies with the law under its duties as a co-fiduciary as provided in ERISA, 29 U.S.C. § 1105, even if the employer prepares or disseminates the SPD.

43. United violated ERISA and breached its fiduciary duties by failing to disclose the reimbursement rules it used to reduce members' benefits, by making retroactive benefit claim denials without proper disclosure or following required procedures, by seeking to impose new policies after-the-fact in an effort to compel payments by providers, by improperly excluding benefits for safe and effective services based on an incorrect determination that they were not Covered Services, by improperly recouping benefits or suing for repayment of benefits that were rightfully paid to Plaintiffs, and by failing to fulfill its obligations of good faith, due care and loyalty.

44. Under ERISA:

> The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

45. As the definition makes clear, United's new policies as applied to Providers

constitute "adverse benefit determinations" under ERISA. The requests for recoupment are based on United's determination that the services at issue were not "covered," and the forced recoupment or withholding of authorized benefits constitutes a "reduction" in benefits or "a failure to provide or make payments (in whole or in part) for a benefit," thereby satisfying the requirement for an adverse benefit determination.

46. ERISA further establishes what steps must be followed once an "adverse benefit determination" is reached, including the following:

> [T]he plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. . . . The notification shall set forth, in a manner calculated to be understood by the claimant – (i) The specific reason or reasons for the adverse determination; (ii) Reference to the specific plan provisions on which the determination is based; (iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review . . . (29 CFR 2560.503-1(g)).

47. In addition, ERISA requires that each claimant be given "a reasonable opportunity to appeal an adverse benefit determination" and to receive a "full and fair review of the claim," (29 CFR 2560.503-1(h)(1)), all within clear and explicit timing requirements.

48. United utterly failed and continues to fail to comply with any of the ERISA requirements. After making benefit determinations, pursuant to which it found that the specific health care services at issue were Covered Benefits of its health care plans and subsequently paid benefits to the providers, United reversed its coverage decisions. United subsequently informed these Providers that it was determining that those same services were no longer deemed to be Covered Services and demanded that the providers repay United.

49. United's actions represent after-the-fact adverse benefit determinations under ERISA that would have the effect of creating new liabilities for the members to the providers.

Yet, United failed to inform United Insureds or their providers of their actions, including by failing to provide necessary disclosures or documentation required under ERISA either to the members or the providers.

50. Because of United's failure to comply with the steps required under ERISA to pursue an adverse benefit determination, its actions in demanding recoupment are invalid and unenforceable, and its coverage determinations should be deemed to be arbitrary and capricious.

51. Even were United to have complied with its procedural obligations under ERISA, it has no legal right to recoup or pursue repayment of such funds paid to Providers, based on retrospective reversals of prior benefit determinations. Each recoupment demand issued by United is a claim for restitution under ERISA. Yet, ERISA does not permit restitution unless the assets at issue are easily identified and separate from other assets, which these are not. Providers obtained the funds in good faith and expended them or otherwise acted based on the assumption that such payments were proper. As there is no dispute that the services at issue were provided by the Providers, and that they billed and received payment for these services in good faith, ERISA does not permit restitution, and equity demands that the providers be entitled to keep such payments. United should therefore be estopped from seeking recoupment or retaining any funds that were paid pursuant to its demands, or should otherwise be found to have waived its ability to collect.

CLASS DEFINITIONS

52. The Individual Plaintiffs bring this action on their own behalf and on behalf of an "ERISA Class," defined as:

> All healthcare providers who, from six years prior to the filing date of this action to its final termination ("ERISA Class Period"), provided healthcare services to patients insured under healthcare plans governed by ERISA and insured or administered by Defendants, and who, after having received payments from Defendants, were subjected to retroactive requests for repayment of all or a

portion of such payments based on a determination that the services were not Covered Services or otherwise medically necessary.

53. The Individual Plaintiffs bring claims against Defendants on their own behalf and on behalf of the ERISA Class, and the OSCA brings claims against Defendants in a representational capacity on behalf of its members, (1) to enjoin Defendants from continuing to compel return of prior payments of plan benefits; (2) to order Defendants to return to all Class members all funds, plus interest, that Defendants have withheld to offset the amounts demanded or that have been paid by Class members to Defendants in response to such demands; and (3) to declare that any future efforts to recoup payments for errors or mistakes in prior payments must comply with the specific requirements under ERISA for adverse benefit determinations.

COMMON CLASS CLAIMS, ISSUES AND DEFENSES FOR THE CLASS

54. The following common class claims, issues and defenses for the Plaintiffs and the Class arise for the defined Class Period:

(1) Whether Defendants' efforts to compel recoupment of previously paid benefits as describer herein violated ERISA, or other applicable law;

(2) Whether Defendants' determinations that the chiropractic services detailed herein are excluded from coverage under the terms of its health care plans are in violation of ERISA, or other applicable law;

(3) Whether ERISA requires each Class member to prove exhaustion or other legal reason excusing exhaustion;

(4) Whether Defendants' actions with regard to Class members result in a waiver of any objection to the validity of any assignments that may have been given by United Insureds, or whether Defendants are otherwise estopped from asserting such an objection;

(5) Whether Class members may recover amounts repaid to Defendants or unpaid benefits and if so, the amounts they should receive;

(6) Whether Defendants' failure to provide accurate plan documents, EOCs, SPDs and other information upon request entitles Class members to any relief;

(7) Whether, in addition to unpaid benefits, interest should be added to the payment of unpaid benefits under ERISA;

(8) Whether Defendants' claims review procedures comply with ERISA;

(9) The standard of review applicable to evaluate Defendants' benefit determinations;

(10) Whether Defendants' forced recoupment, as detailed herein, is in violation of ERISA as it relates to restitution; and

(11) What the applicable statute of limitations periods are for the claims of Class members.

ADDITIONAL CLASS ACTION ALLEGATIONS

55. The members of the Class are so numerous that joinder of all members is impracticable. Upon information and belief, the Class consists of thousands of health care providers who provided services to United Insureds covered by commercial group health plans insured, offered, or administered by Defendants. The precise number of members in the Class is within Defendants' custody and control. Based on reasonable estimates, the numerosity requirement of Rule 23 is easily satisfied for the Class. Common questions of law and fact exist as to all Class members and predominate over any questions affecting solely individual members of the Class, including the class action claims, issues and defenses listed above.

56. The Individual Plaintiffs' claims are typical of the claims of the Class members because, as a result of the conduct alleged herein, Defendants have breached their statutory and contractual obligations to the Individual Plaintiffs and the Class through and by uniform patterns or practices as described above, including but not limited to their efforts to compel repayment of prior paid benefits and their forced recoupment through conversion or withholding of unrelated benefit payments.

57. The Individual Plaintiffs will fairly and adequately protect the interests of the members of the Class, are committed to the vigorous prosecution of this action, have retained counsel competent and experienced in class action litigation and in the prosecution of ERISA

claims and have no interests antagonistic to or in conflict with those of the Class. For these reasons, the Individual Plaintiffs are adequate class representatives under Fed. R. Civ. P. 23.

58. The prosecution of separate actions by individual members of the Class would create a risk of inconsistent or varying adjudications that could establish incompatible standards of conduct for Defendants.

59. A class action is superior to other available methods for the fair and efficient adjudication of this controversy because joinder of all members of the Class is impracticable. Further, because the unpaid benefits denied Class members may be relatively small, the expense and burden of individual litigation make it impossible for the Class members individually to redress the harm done to them. Defendants maintain computerized claims information that enables them to calculate unpaid amounts resulting from their benefit determinations for Class members. Given the uniform policy and practices at issue, there will also be no difficulty in the management of this litigation as a class action.

COUNT I

CLAIM FOR BENEFITS UNDER GROUP PLANS GOVERNED BY ERISA
(on behalf of Plaintiffs and the ERISA Class)

60. The allegations contained in this Complaint are realleged and incorporated by reference as if fully set forth therein. Count I is brought under 29 U.S.C. § 1132(a)(1)(B).

61. United must pay benefits to United Insureds, or to their providers pursuant to assignments, that are insured, funded or administered by United pursuant to the terms of their United Plans.

62. To the extent United has determined that charges submitted for reimbursement on behalf of Plaintiffs and the members of the ERISA Class are no longer Covered Services under its health care plans, such a finding is an “adverse benefit determination” under ERISA.

63. United sought to compel the Individual Plaintiffs and the members of the ERISA Class to repay previously paid benefits without complying with terms and conditions required by ERISA for dealing with adverse benefit determinations.

64. United violated its legal obligations under ERISA and federal common law each time it denied benefits as detailed herein without complying with ERISA's requirements for dealing with adverse benefit determinations.

65. United's lack of disclosure to the United Insureds and Providers relating to adverse benefit determinations, as required under ERISA, violated its legal obligations.

66. Due to United's failure to comply with ERISA in pursuing recoupment efforts, it is estopped from pursuing such efforts and, further, is required to repay members of the ERISA Class any amounts: 1) paid to United in response to its recoupment demands; or 2) unilaterally withheld by United in order to apply them to sums United demanded be repaid.

67. ERISA precludes United's recoupment efforts, as they do not satisfy the requirements for equitable restitution.

68. Due to United's failure to comply with ERISA in making the above-detailed adverse benefit determinations, United is estopped from making such findings and precluded from denying coverage without complying with ERISA.

69. The Individual Plaintiffs, on their own behalf and on behalf of the members of the Class, seek unpaid benefits, interest back to the date their claims were originally submitted to United, withdrawal of all claims for rescission or other relief against Providers or members of the ERISA Class, and repayment of any amounts paid by or withheld from members of the ERISA Class in response to any such letters or demands. Plaintiffs, including the OSCA, also sue for declaratory and injunctive relief related to enforcement of plan terms, and to clarify their rights

to future benefits. Plaintiffs further request attorneys' fees, costs, prejudgment interest and other appropriate relief against United.

COUNT II

FAILURE TO PROVIDE FULL AND FAIR REVIEW AS REQUIRED BY ERISA
(on behalf of Plaintiffs and the ERISA Class)

70. The allegations contained in this Complaint are realleged and incorporated by reference as if fully set forth herein.

71. United functioned and continues to function as the "plan administrator" within the meaning of such term under ERISA. During the Class Period, Subscribers were entitled to receive a "full and fair review" of all claims denied by United, and entitled to assert a claim under 29 U.S.C. § 1132(a)(3) for failure to comply with these requirements.

72. Although United was obligated to do so, it failed to provide a "full and fair review" of denied claims pursuant to 29 U.S.C. § 1133 (and the regulations promulgated thereunder) for Plaintiffs and the Class by making claims denials that are inconsistent with or unauthorized by the terms of Members' EOCs and SPDs, as well as by failing to disclose its methodology and other critical information relating to such claims denials.

73. By engaging in the conduct described herein, including using improper, invalid and undisclosed policies relating to the specified health care services, making baseless threats regarding overpayments and the pursuit of litigation, withholding payments for properly submitted claims to apply toward the demanded amount, and for effecting other systematic benefit reductions without disclosure or authority under the plans, United failed to comply with ERISA, its regulations and federal common law.

74. As a result, United failed to provide a "full and fair review," failed to provide reasonable claims procedures, and failed to make necessary disclosures to its Insureds.

75. Appeals of Providers and members of the ERISA Class should be deemed exhausted or excused by virtue, *inter alia*, of United's numerous procedural and substantive violations.

76. The failed appeals of the Individual Plaintiffs show the futility of exhausting appeals to United. Exhaustion of internal appeals under ERISA should, therefore, be deemed to be futile.

77. During the Class Period, the Individual Plaintiffs and the members of the ERISA Class have been harmed by United's failure to provide a "full and fair review" of appeals under 29 U.S.C. § 1133, and by its failure to disclose relevant information in violation of ERISA and the federal common law. All Plaintiffs and the members of the ERISA Class are also entitled to injunctive and declaratory relief to remedy United's continuing violation of these provisions.

COUNT III

EQUITABLE RELIEF UNDER ERISA

78. The allegations contained in this Complaint are realleged and incorporated by reference as if fully set forth herein.

79. United issued demand letters to Providers seeking to compel repayment of previously paid benefits, and forcibly recouped benefits from unrelated claims to apply toward the alleged overpayment, without any authority or validation, or sought to compel payment through lawsuits or other actions. In so doing, United failed to comply with the terms and conditions of its healthcare plans, both those under ERISA and otherwise, with regard to making adverse benefit determinations.

80. United has no legal basis upon which to pursue recoupment from Providers, the Individual Plaintiffs and other Class members, but is merely seeking to coerce payments for retrospective adverse benefits determinations by United.

81. All Plaintiffs seek appropriate declaratory and injunctive relief to enjoin United from pursuing its efforts to coerce recoupment or otherwise compel payment and, further, to order United to return any funds it has received or withheld from the Individual Plaintiffs and members of the Class as a result of its recoupment efforts.

WHEREFORE, Plaintiffs demand judgment in their favor against Defendants as follows:

A. Certifying the Class, as set forth in this Complaint, and appointing the Individual Plaintiffs as Class representatives.

B. Declaring that United has breached the terms of its EOCs and SPDs and awarding unpaid benefits to the Individual Plaintiffs and the members of the Class, as well as awarding injunctive and declaratory relief to prevent United's continuing actions detailed herein that are undisclosed and unauthorized by EOCs and SPDs;

C. Declaring that United failed to provide a "full and fair review" to the Individual Plaintiffs and ERISA Class members under 29 U.S.C. § 1133, and awarding injunctive, declaratory and other equitable relief to ensure compliance with ERISA and its regulations;

D. Declaring that United violated its disclosure and related obligations under ERISA and federal common law, for which all Plaintiffs and ERISA Class members are entitled to injunctive, declaratory and other equitable relief;

E. Declaring that United violated federal claims procedures, and awarding declaratory and injunctive relief to remedy such violations;

F. Ordering United to recalculate and issue unpaid benefits to Providers that were unpaid or underpaid as a result of United's actions, as detailed herein, with interest;

G. Enjoining United from continuing to pursue their recoupment efforts as detailed

herein, and ordering them to pay proper benefits in the form of a return of any sums previously paid by or withheld from the Individual Plaintiffs and other Class members in response to United's recoupment efforts;

H. Awarding Plaintiffs disbursements and expenses of this action, including reasonable counsel fees, in amounts to be determined by the Court;

I. Awarding interest from the date of initial benefit reductions for the Individual Plaintiffs and members of the Class for all improperly billed amounts; and

J. Granting such other and further relief as is just and proper.

CARELLA, BYRNE, CECCHI,
OLSTEIN, BRODY & AGNELLO
Attorneys for Plaintiffs

By: /s/ James E. Cecchi
JAMES E. CECCHI

Dated: January 24, 2011

Of counsel:

D. Brian Hufford
Robert J. Axelrod
Susan J. Weiswasser
POMERANTZ HAUDEK
GROSSMAN & GROSS LLP
100 Park Avenue
New York, New York 10017
(212) 661-1100

Vincent N. Buttaci
John W. Leardi
Paul D. Werner
BUTTACI & LEARDI, LLC
103 Carnegie Center, Suite 101
Princeton, New Jersey 08540
(609) 799-5150

Kimberly A. Driggers
BROOKS, LeBOEUF, BENNETT,
FOSTER & GWARTNEY, P.A.
909 East Park Avenue
Tallahassee, Florida 32301
(850) 222-2000

JS 44 (Rev. 11/04)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. (SEE INSTRUCTIONS ON THE REVERSE OF THE FORM.)

I. (a) PLAINTIFFS

Premier Health Center, P.C., Judson G. Sprandel, II, D.C. and Ohio State Chiropractic Association

(b) County of Residence of First Listed Plaintiff Bergen
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorney's (Firm Name, Address, and Telephone Number)

Carella, Byrne, Cecchi, Olstein, Brody & Agnello, 5 Becker Farm Road, Roseland, New Jersey 07068

DEFENDANTS

UnitedHealth Group, United Healthcare Services, Inc., Health Net of the Northeast, Inc. and Health Net of New York, Inc.

County of Residence of First Listed Defendant
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE LAND INVOLVED

Attorneys (If Known)

II. BASIS OF JURISDICTION (Place an "X" in One Box Only)

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question (U.S. Government Not a Party)
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity (Indicate Citizenship of Parties in Item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES (Place an "X" in One Box for Plaintiff and One Box for Defendant)
(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT (Place an "X" in One Box Only)

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excl. Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury

PERSONAL INJURY
- ☐ 362 Personal Injury - Med. Malpractice
- ☐ 365 Personal Injury - Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing Accommodations
- ☐ 444 Welfare
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 440 Other Civil Rights

PRISONER PETITIONS
- ☐ 510 Motions to Vacate Sentence

Habeas Corpus:
- ☐ 530 General
- ☐ 535 Death Penalty
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition

FORFEITURE/PENALTY
- ☐ 610 Agriculture
- ☐ 620 Other Food & Drug
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 630 Liquor Laws
- ☐ 640 R.R. & Truck
- ☐ 650 Airline Regs
- ☐ 660 Occupational Safety/Health
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Mgmt. Relations
- ☐ 730 Labor/Mgmt. Reporting & Disclosure Act
- ☐ 740 Railway Labor Act
- ☐ 790 Other Labor Litigation
- ☒ 791 Empl. Ret. Inc. Security Act

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 840 Trademark

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS - Third Party 26 USC 7609

OTHER STATUTES
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit
- ☐ 490 Cable/Sat TV
- ☐ 810 Selective Service
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 875 Customer Challenge 12 USC 3410
- ☒ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 892 Economic Stabilization Act
- ☐ 893 Environmental Matters
- ☐ 894 Energy Allocation Act
- ☐ 895 Freedom of Information Act
- ☐ 900 Appeal of Fee Determination Under Equal Access to Justice
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN (Place an "X" in One Box Only)

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from another district (specify) ☐ 6 Multidistrict Litigation ☐ 7 Appeal to District Judge from Magistrate Judgment

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing (**Do not cite jurisdictional statutes unless diversity**):
29 U.S.C. sec 1132 et seq.

Brief description of cause:
Action by providers against insurers that engaged in unlawful post-payment audits and recoupments in violation

VII. REQUESTED IN COMPLAINT:

☑ CHECK IF THIS IS A **CLASS ACTION** UNDER F.R.C.P. 23

DEMAND $

CHECK YES only if demanded in complaint:
JURY DEMAND: ☐ Yes ☑ No

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE _____ DOCKET NUMBER _____

DATE
01/24/2011

SIGNATURE OF ATTORNEY OF RECORD

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____