

NOV 14 2001

**IN THE SUPREME COURT OF THE STATE OF NEW YORK
IN AND FOR THE COUNTY OF MONROE**

**WILLIAM A. DOLAN, M.D. and
SYLVIA W. NORTON, M.D., on behalf
of themselves and all others similarly
situated,**

Plaintiffs,

vs.

**EXCELLUS, INC.; EXCELLUS
HEALTH PLAN, INC.; and
EXCELLUS BENEFITS SERVICES,
INC.,**

Defendants.

Index No. 9748-01

**AMENDED CLASS ACTION
COMPLAINT**

Jury Trial Demanded

NOV 15 2001

RECEIVED

Plaintiffs William A. Dolan, M.D. and Sylvia W. Norton, by their attorneys, bring this action pursuant to New York Civil Practice Law & Rule ("CPLR") § 901 against Excellus, Inc.; Excellus Health Plan, Inc.; and Excellus Health Benefits Services, Inc. (collectively referred to herein as "Excellus" or "defendants") and alleges the following upon information and belief, except as to paragraphs pertaining to plaintiffs' own actions, which are alleged upon personal knowledge:

INTRODUCTION

1. Plaintiffs bring this action on their own behalf and on behalf of a class (the "Class")(sometimes referred to herein as "MSSNY members") of all other physicians who are members of MSSNY and who are, or were, participating physicians in defendants' physician

network at any time during the period from August 15, 1998 through the present (the "Class Period"). Plaintiffs do not bring this action as assignees of enrollees' benefits. Moreover, this action does not otherwise seek benefits or other remedies under the Employee Retirement Security Act of 1974 ("ERISA"), nor does it arise under or relate to ERISA.

2. Throughout the relevant period, defendants have engaged in a pattern of improper and deceptive conduct and business practices, by engaging in a scheme to deny, impede, delay, and reduce lawful reimbursement to plaintiffs and other members of the Class who rendered medically necessary healthcare services to members of defendants' managed care plans.

3. In addition, as a result of the extraordinarily unequal bargaining positions between the MSSNY members and defendants, and the physicians' reliance on Excellus to provide access to significant portions of their patient information base, Excellus has been able to force plaintiffs and the members of the Class to enter into one-sided contracts which infringe upon the doctor-patient relationship and threaten the continuity of care physicians provide to their patients.

4. As discussed in detail below, defendants have employed a variety of means to effect their improper and deceptive scheme and breaches of contract, including, but not limited to, one or more of the following practices:

- Defendants systematically deny reimbursement to MSSNY members for medically necessary services by, *inter alia*, (i) routinely and unjustifiably refusing to pay for, or reducing payment for, more than one healthcare service per visit or incident -- referred to as "bundling"; (ii) routinely and unjustifiably reducing retroactively the amount of reimbursement remitted to MSSNY members, referred to as "downcoding"; (iii) routinely and unjustifiably

denying increased levels of reimbursement for complicated medical cases which require MSSNY members to expend extra time and resources on the treatment of the patient -- referred to as "modifiers"; (iv) routinely and unjustifiably denying payment for procedures performed during "global periods" for *unrelated* procedures; and (v) routinely and unjustifiably refusing to pay for treatments by physician specialists by falsely claiming that referrals were not obtained from the patients' primary care physicians.

- Defendants systematically deny payment to MSSNY members for medically necessary claims to achieve internal financial targets without regard for individual patients' medical needs by, *inter alia*, (i) improperly employing software programs to automatically downcode procedures and/or deny payment to MSSNY members identified as "high utilizers," without any clinical review, oversight or justification; and (ii) improperly applying so-called "guidelines" in a manner that Excellus knows is reasonable for the purpose of denying payment for coverage for medically necessary treatments.

- Defendants fail to provide adequate staffing to handle MSSNY members' inquiries. In this regard, Excellus has created and maintains an inefficient administrative system designed to frustrate payment to plaintiffs and the Class by requiring physicians to make excessive telephone inquiries to obtain proper reimbursement of claims.

- Defendants routinely and unjustifiably fail to make payments to MSSNY members within the time period prescribed by applicable provisions of New York State law, and routinely and unjustifiably fail to pay interest on past-due claims required under Excellus'

contractual agreements with plaintiffs and the members of the Class and under applicable provisions of New York State law.

- Defendants fail to provide sufficient explanation for their payment denials and reductions.
- Defendants consistently refuse to provide participating physicians with Excellus' fee schedules for Current Procedure Terminology Codes ("CPT Codes") (the codes recognized by physicians and insurers for reimbursement).
- Defendants require physicians to enter into one-sided physician agreements in order for them to provide medical care to patients who receive healthcare through defendants' managed care plans.

5. As a result of their improper, unfair and deceptive scheme, defendants have deprived MSSNY members of millions of dollars of lawful reimbursement for healthcare services provided to defendants' plan members.

6. Adequate and timely reimbursements to MSSNY members are also necessary to ensure that physicians are able to maintain their practices and provide medically sound care and continuity of care to patients. The delivery of healthcare services patients have been promised by defendants depends on reimbursement adequate to cover the costs of delivering such healthcare. Defendants' failure to provide reimbursement to MSSNY members which is adequate to cover the costs of delivering healthcare services to Excellus' enrollees has resulted in tremendous hardships for defendants' participating physicians.

7. Defendants' conduct in this regard also injures consumers of defendants' healthcare products and the general public. Defendants' conduct has adversely impacted, and continues to adversely impact, members of defendants' plans and the general public by, among other things: (a) imposing financial hardships, and in some cases threatening the continued viability of the practices run by plaintiffs and the Class; (b) threatening the continuity of care provided to patients by plaintiffs and the Class, as required by sound medical judgment; (c) requiring plaintiffs and the Class to expend considerable resources in seeking reimbursement that could otherwise be available to provide enhanced healthcare services to defendants' plan members; (d) making it more costly and difficult for plaintiffs and the Class to maintain and enhance the availability and quality of care that all patients receive; and (e) increasing the costs of rendering healthcare services in New York as a result of the additional costs incurred, and considerable effort expended by plaintiffs and the members of the Class, in seeking reimbursement from Excellus for services rendered.

THE PARTIES

8. Plaintiff William A. Dolan, M.D. is an orthopaedic surgeon and a member of the Medical Society of the State of New York ("MSSNY") who resides in Monroe County, New York, with his principal place of business located at 880 Westfall Road, Rochester, New York 14618. During the class period, Dr. Dolan has been a participating provider with Excellus.

9. Plaintiff Sylvia W. Norton, M.D. is an ophthalmologist and a member of the Medical Society of the State of New York ("MSSNY") who resides in Onandaga County, New York, with her principal place of business located at Madison-Irving Medical Center, 475 Irving

Avenue, Suite 110, Syracuse, New York 13210. During the class period, Dr. Norton has been a participating provider with Excellus.

10. Defendant Excellus Health Plan, Inc. is a New York corporation with its principal place of business at 165 Court Street, Rochester, New York. Excellus Health Plan, Inc. is engaged in the business of offering healthcare products to New York residents. Excellus Health Plan, Inc. also does business as BlueCross BlueShield of Central New York, BlueCross BlueShield of the Rochester Area and BlueCross BlueShield of Utica-Watertown.

11. Defendant Excellus, Inc. is a New York corporation with its headquarters and principal place of business at 150 East Main Street, Rochester, New York.

12. Defendant Excellus Health Benefit Services, Inc. is a New York corporation with its principal place of business at 30 Perinton Hills Mall, Fairport, New York.

JURISDICTION AND VENUE

13. The claims alleged herein arise under the common law, § 349 of Article 22-A of the General Business Law, entitled Consumer Protection from Deceptive Acts and Practices ("GBL § 349"), and other statutory and common law.

14. This Court has jurisdiction over Excellus pursuant to CPLR § 301 because Excellus does sufficient business in New York, has sufficient minimum contacts with New York, including offices located here, and otherwise intentionally avails itself of the markets in New York by establishing and maintaining physician networks and administering healthcare plans with tens of thousands of subscribers in New York, and by promoting, marketing, selling and

distributing its healthcare services in this state, so as to render the exercise of jurisdiction by the New York courts permissible under traditional notions of fair play and substantial justice.

15. This Court is a proper venue for this action given that Excellus has its principal place of business in Rochester, conducts a substantial amount of its business in Rochester, has numerous participating providers in Rochester, and provides healthcare products and services to numerous Rochester residents. Moreover, it is the chosen forum of the named plaintiffs.

CLASS ACTION ALLEGATIONS

16. Plaintiffs bring this class action in accordance with CPLR § 901. Plaintiffs bring this action on their own behalf and on behalf of a class (the "Class") of all other physicians who are members of MSSNY and who are, or were, participating physicians in defendants' physician network at any time during the period from August 15, 1998 through the present (the "Class Period"). Plaintiffs do not bring this action as assignees of enrollees' benefits. Moreover, this action does not otherwise seek benefits or other remedies under ERISA, nor does it arise under or relate to ERISA.

17. Excluded from the Class are defendants, any entity in which any defendant has a controlling interest, or is a parent or subsidiary of, or any entity that is controlled by, a defendant, and any of the officers, directors, employees, affiliates, legal representatives, heirs, predecessors, successors and assigns thereof.

18. This action is brought as a class action under CPLR § 901 for the following reasons:

a. The Class consists of thousands of physicians and is thus so numerous that joinder of all members, whether otherwise required or permitted, is impracticable;

b. There are questions of law or fact common to the Class that predominate over any questions affecting only individual members, including:

i. whether defendants have engaged in an unfair and/or deceptive scheme designed to wrongfully delay, impede, deny, or reduce payment of claims for healthcare services rendered to defendants' plan members for which plaintiffs and members of the Class were entitled to recover;

ii. whether defendants have breached their contracts with MSSNY members;

iii. whether defendants have refused, without lawful justification, to pay all or part of lawful claims for healthcare services provided by plaintiff physicians and other members of the Class either by "bundling" claims for multiple services, "downcoding" those services rendered, refusing to pay for "modifiers," or denying payment for healthcare services that fall within the "global period" for a wholly unrelated procedure, or refusing to pay specialists for lack of a referral when a referral was submitted;

iv. whether defendants have directed their internal personnel to routinely reduce or deny claims for payment of healthcare services to members of defendants' plans treated by plaintiffs and the members of the Class;

- v. whether defendants have improperly used software programs to automatically downcode and/or deny payment to doctors identified as high utilizers without any clinical review or oversight;
- vi. whether defendants have improperly delayed payments and/or refused to pay interest on late payments in violation of their agreements with plaintiffs and the Class and applicable New York State law;
- vii. whether defendants have violated New York Public Health Law § 4406-c;
- viii. whether defendants have knowingly and improperly applied so-called "guidelines" in evaluating claims for medical necessity as a means to wrongfully deny reimbursement;
- ix. whether defendants have failed to provide participating physicians with fee schedules;
- x. whether defendants have failed to provide adequate explanations for the denial of claims for reimbursement;
- xi. whether defendants have failed to provide adequate staffing to handle physician inquiries; and
- xii. whether plaintiffs and the other members of the Class have sustained damages and the proper measure of damages.

19. The claims asserted by plaintiffs are typical of the claims of the members of the Class.

20. Plaintiffs will fairly and adequately protect the interests of the Class, and plaintiffs have retained attorneys experienced in class and complex litigation as their counsel.

21. A class action is superior to other available methods for the fair and efficient adjudication of this controversy for at least the following reasons:

a. absent a class action, Class members will continue to suffer damage and defendants' violations of law will proceed without remedy, while defendants continue to retain their ill-gotten gains;

b. it would impose a substantial hardship on most individual members of the Class to prosecute individual actions;

c. when the liability of the defendants has been adjudicated, claims of all members of the Class can be determined by the Court;

d. this action will cause an orderly and expeditious administration of the Class claims and economies of time, effort and expense will be fostered, and uniformity of decisions will be ensured; and

e. this action presents no difficulties that would impede its management by the Court as a class action.

FACTUAL ALLEGATIONS

Background

22. Excellus is among the largest health insurers in the New York area and sells a variety of healthcare insurance products. Each healthcare product offered by Excellus in the

State of New York allows members to select physicians from a network of participating physicians.

23. Excellus Inc. was formed in January 1996 when it took over Blue Cross Blue Shield of Central New York. Simultaneously, Blue Cross Blue Shield of Central New York changed its name to Excellus Health Plan, Inc. A year later, in January 1997, Excellus, Inc. took control of Excellus BlueCross BlueShield of the Rochester Area. In November of that same year, BlueCross BlueShield of Utica-Watertown merged into Excellus, Inc. By that time, Excellus had increased its coverage area to 31 counties in Upstate New York, with over 1.67 million members. Effective December 31, 1998, the BlueCross BlueShield Plans of Central New York, the Rochester Area and Utica-Watertown restructured their corporations into a single legal entity called Excellus Health Plan, Inc.

24. Excellus is now seeking to merge with the Buffalo-based Univera HMO. The merger would create New York's second-largest health insurer, and give the new organization more than 2 million members and market share of 70 percent or more in some counties.

25. Excellus contracts with independent practice associations ("IPAs") (comprised of groups of physicians) other medical groups, and individual physicians, to provide health care services to Excellus members. These contracts are entered into for the benefit of individual physicians who provide healthcare services to Excellus members.

26. Defendants' agreements with MSSNY physicians and IPAs all provide that Excellus will reimburse participating physicians for the provision of medically necessary healthcare services to defendants' plan members.

27. With respect to MSSNY physicians who contract directly with Excellus, they enter into standardized, one-sided agreements. Although the terms of the agreements are far less favorable to the physicians than to defendants, physicians are compelled to sign the agreements because the physicians need to participate in defendants' health plans to increase and/or maintain their patient volume, and to make finite and necessary healthcare services available to as many people in the community as possible.

28. The relevant contractual terms contained in these agreements are identical or substantially similar. Excellus does not allow individual physicians to negotiate these agreements. These agreements all provide that MSSNY members agree to render medically necessary healthcare services to defendants' plan members in exchange for prompt reimbursement from Excellus at specified rates.

29. With respect to reimbursement, the agreements state as follows:

Reimbursement of Physician. Excellus/BCBS will compensate Physician for all Covered Services rendered to Members at the rate and/or in the manner described in Exhibit A of this Agreement. Excellus/BCBS may amend the amounts payable to Physician as set forth in Exhibit A at any time upon sixty (60) days prior written notice to Physician.

"Attachment A" states that physicians will be paid in accordance with Excellus' fee schedules, but no fee schedules are attached to the agreement. Moreover, with respect to the method of obtaining payment for Covered Services, Excellus' agreements state:

Billing and Payment. Physician shall bill Excellus/BCBS or its designee for Covered Services rendered by Physician to Members in a manner and format acceptable to Excellus/BCBS. The billing form should be submitted within 30 days of the date of service, but will be accepted so long as submitted within 90 days of the date of service. If Physician submits claims electronically to Medicare

then Physician agrees to submit claims electronically to Excellus/BCBS. We will promptly pay Physician directly. Excellus/BCBS will only make payment pursuant to correctly-billed claim forms which include appropriate procedure and diagnosis codes. Physician agrees to bill utilizing the most current and inclusive codes (5 digit CPT) that accurately reflect the services rendered.

30. According to the express terms of the agreements, participating physicians are also required to cooperate with defendants in their efforts to conduct quality assurance and utilization review. The agreements state:

6. **Utilization Management, Quality Improvement and Other Procedures.** Physician agrees to cooperate in, and comply with, the standards and requirements of each of the following Excellus/BCBS initiatives; quality improvement, utilization management, credentialing, member grievance, and clinical encounter data collection programs related to any of this initiatives. These include, but are not limited to, reviews and action plans to improve the quality of care delivered to Members, data collection and measuring tools such as HEDIS, the New York State Quality Assurance Reporting Requirements (QARR) and similar initiatives, as well as precertification, referral authorizations and other programs designed to assure appropriate utilization at reasonable cost....

These terms can be, and are, utilized in an improperly narrow fashion. Excellus alters these contractual terms to deny providers payment for services rendered to plan members.

31. As the foregoing paragraph indicates, defendants employ "utilization review" systems to determine, both prospectively and retroactively, whether, Excellus, in its sole discretion, deems healthcare services to be compensable. However, neither the agreements nor any other documents provided to participating physicians contain an adequate description of any guidelines, policies, or procedures for determining whether a healthcare service is compensable. This determination is within defendants' sole discretion, and is subject to change from one claim to another.

32. As set forth in detail below, contrary to the terms of its agreements with IPAs and participating physicians, defendants have refused to pay for all or a portion of the medically necessary healthcare services provided by MSSNY members to defendants' plan members and have delayed or reduced payment for other services. Additionally, defendants have failed to act in good faith, choosing instead to wrongfully exploit the utilization review process to delay and deny payment, and/or to compromise MSSNY members' ability to receive the reimbursement to which they are entitled.

Defendants' Improper and Unfair Contracting Policies and Practices

33. In order to treat patients who are insured by Excellus, Excellus requires MSSNY members, either directly or through IPAs or other medical groups, to enter into the aforementioned agreements with Excellus.

34. If physicians refuse to enter into Excellus' one-sided agreements, those physicians are effectively prevented from seeing and treating patients, including long-time patients, who are covered for health insurance through any of Excellus' plans.

35. In effect, physicians who object to contract provisions contained in Excellus' agreements are faced with an untenable choice. They can either accept agreements that are unfair to both physicians and patients, or they can choose to no longer treat patients who are insured by Excellus. As Excellus continues to gain market share through the acquisition of new companies, taking control of more members, the pressure becomes increasingly great for MSSNY members to join Excellus' network.

