Steven A. Schwartz (Pa. I.D No. 50579)
Alison G. Gushue (Pa. I.D. No. 203669)
CHIMICLES & TIKELLIS LLP
361 West Lancaster Avenue
Haverford, PA 19041
Tel: 610-642-8500
Fax: 610-649-3633
Email: **SAS@Chimicles.com**
AGG@Chimicles.com

Other Counsel listed on signature page.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

AMERICAN CHIROPRACTIC ASSOCIATION, on its own behalf and in a representational capacity on behalf of its members, STEVEN G. CLARKE, D.C., individually, and on behalf of all other similarly situated Doctors of Chiropractic, and CAROL A. LIETZ, individually, and on behalf of all other similarly situated health insurance subscribers, *Plaintiffs*, - against - AMERICAN SPECIALTY HEALTH INCORPORATED , AMERICAN SPECIALITY HEALTH NETWORKS, INC, CIGNA CORPORATION and CONNECTICUT GENERAL LIFE INSURANCE COMPANY, *Defendants*.	Case No. **CLASS ACTION COMPLAINT**

Plaintiffs American Chiropractic Association ("ACA"), on behalf of itself and in a representational capacity on behalf of its members; Steven G. Clarke, D.C., on behalf of himself

and a proposed class of all similarly situated Doctors of Chiropractic; and Carol A. Lietz, on behalf of herself and a proposed class of all similarly situated health insurance subscribers, bring this Class Action Complaint (the "Complaint") against Defendants American Specialty Health Incorporated and American Specialty Health Networks, Inc. (collectively, "ASHN"), and CIGNA Corporation ("CIGNA") and Connecticut General Life Insurance Company ("CGLIC"). CIGNA and CGLIC are collectively referred to herein as "CIGNA," unless otherwise indicated. ASHN and CIGNA are collectively referred to herein as "Defendants." Plaintiffs hereby allege upon personal knowledge as to themselves and their own acts, and upon information and belief as to all other matters, based upon, *inter alia*, the investigation made by and through their attorneys, as follows:

SUMMARY OF PLAINTIFFS' ALLEGATIONS

1. Plaintiff ACA is a chiropractic professional association representing its chiropractic physician members (the "ACA Members") in this action and seeking to obtain appropriate equitable and injunctive relief as detailed herein.

2. Plaintiff Clarke is a licensed doctor of chiropractic ("D.C.") who regularly provides health care services to patients who are insured as participants or beneficiaries under health care plans issued or administered by CIGNA ("CIGNA Insureds"). Dr. Clarke received assignments of benefits from their patients. Pursuant to those assignments, Dr. Clarke is entitled to submit claims to and be paid benefits directly by Defendants under the terms of the applicable health care plans ("CIGNA Plans" or "Plans"). Moreover, CIGNA and ASHN have waived any right to challenge any assignments asserted by Dr. Clarke due to the manner in which it treated his claims and paid him directly for providing services to CIGNA Insureds. Dr. Clarke does not assert claims or seek relief under any in-network ("INET") contracts with Defendants. He is an

out-of-network provider who has not agreed to accept any discounted payments from Defendants or to comply with their internal policies or guidelines.

3. Plaintiff Carol A. Lietz ("Lietz") is a current subscriber to a health care plan offered and administered by CIGNA. Pursuant to internal CIGNA policies, ASHN provides claims administration services with regard to her receipt of chiropractic services.

4. Defendant CIGNA, through its Health Care segment, offers, underwrites, and administers CIGNA Plans, through which healthcare expenses incurred by CIGNA Insureds for services and/or products covered by the Plans ("Covered Services") are reimbursed by and/or through CIGNA, subject to the Plan's terms, conditions, and limitations. CIGNA has entered into a contractual relationship with Defendant ASHN, whereby ASHN serves as the claims administrator for health care claims submitted to CIGNA by CIGNA Insureds or their providers with regard to chiropractic services.

5. Most of the CIGNA Insured patients, on whose behalf Dr. Clarke or other ACA members submit claims, are covered by employee welfare benefit plans issued by or on behalf of private employers and are thereby governed by the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA governs all such plans, whether they are fully insured or self-funded, and is estimated to include more than 170 million insureds nationwide. Leitz's CIGNA Plan is similarly insured by ERISA as she obtained it through her private employer. ERISA-exempt plans include those which are issued by governmental agencies or churches, or for plans acquired by individuals, and not through an employer.

6. Because the benefits paid to CIGNA Insureds or their providers are based on Defendants' evaluation and assessment of the terms and conditions of ERISA Plans, ERISA governs the adjudication and disposition of these benefit payments. Further, because CIGNA

pays Plan benefits directly to the chiropractic providers such as Dr. Clarke as assignees of CIGNA Insureds' claims, such providers – including Dr. Clarke – are ERISA Plan beneficiaries, with derivative standing to assert rights and protections under this statute and under applicable state laws.

7. CIGNA has retained ASHN to administer chiropractic benefits for many of its CIGNA Insureds. CIGNA paid ASHN an administrative fee for overseeing and processing these chiropractic claims. However, CIGNA and ASHN jointly issued false and misleading reports relating to chiropractic claims (including Explanations of Benefits ("EOB") required under ERISA for informing subscribers of how their chiropractic claims have been processed). These falsified reports misrepresented the amount CIGNA Insureds owed for health care services, leading to greater out-of-pocket costs than were properly charged under their CIGNA Plans, while also interfering with the doctor-patient relationship because they mischaracterize the administrative fee owed to ASHN as a medical cost. This practice may also allow CIGNA to report an inaccurate Medical Loss Ratio ("MLR").

8. An MLR represents the percentage of premium income that an insurer pays out in medical expenses on behalf of plan members, as compared to the portion spent toward administrative costs. Under the new federal health care law, the Patient Protection and Affordable Care Act ("PPACA"), CIGNA is required to meet certain MLR requirements in order to avoid paying back rebates of excessive premiums. Through the actions described herein, CIGNA was able to misrepresent the ASHN administrative fee as a medical expense, thereby minimizing the potential for paying rebates under PPACA.

9. As part of its administration of the chiropractic benefits offered under CIGNA Plans, ASHN also adopted utilization review and pre-certification requirements that imposed

restrictions on coverage. These restrictions, however, were not included in the Plans. In fact, in the laws of the State of Missouri laws were incorporated and made part of the Missouri Plans, which include provisions allowing enrollees up to 26 chiropractic visits prior to such pre-certification requirements. ASHN further denied benefits based on flawed and inadequate data. Those denials were not supported by generally accepted chiropractic standards. While ASHN publicly supports coverage of chiropractic services in health insurance plans, its policies are actually designed to discourage chiropractors from providing medically necessary care in order to save CIGNA (and ASHN's other clients) money. These policies, however, conflict with the terms and conditions of the ERISA Plans which cover CIGNA Insureds and are thereby in violation of ERISA. ASHN further makes its coverage decisions without using properly licensed providers in the various states in which it operates, thereby making its decisions improper under ERISA.

10. Dr. Clarke obtains benefit claim assignments from his CIGNA Insureds as a matter of course. These assignments give Dr. Clarke the right to bill and receive benefit payments directly for their services, and to represent the Insureds under ERISA. Additionally, Defendants allow Dr. Clarke to appeal adverse determinations on behalf of the Insureds based on the assignments. Moreover, CIGNA accepts these assignments as valid by dealing directly with Dr. Clarke and paying him directly. Accordingly, CIGNA waived any denial of the validity of the assignments, and is otherwise estopped from asserting such denial. As a result, Dr. Clarke has standing to pursue the ERISA claims asserted.

11. The ACA brings this case on its own behalf and/or in an associational capacity on behalf of its members who have been injured as a result of the egregious acts and practices of Defendants as set forth in the Complaint. The ACA is dedicated to advocating for the rights of

providers and patients alike for the delivery of the highest quality of healthcare. Accordingly, the ACA alleges violations of ERISA and applicable state laws on behalf of their members, and seeks appropriate injunctive relief.

12. Because Defendants' actions were improper and without a valid legal foundation, Plaintiffs seek, among other things, to enjoin Defendants from engaging in the improper practices described herein and to obtain appropriate restitution for losses suffered as a result of ASHN's improper and invalid policies and procedures.

THE PLAINTIFFS

13. Plaintiff Clarke is a licensed chiropractic physician who practices in Nutley, New Jersey, under the name High Street Rehabilitation, LLC. Dr. Clarke brings this action in his own name and on behalf of the company through which he provides health care services to CIGNA Insureds.

14. Pursuant to assignment of benefits he obtained from CIGNA Insured patients, Dr. Clarke has standing to pursue claims under ERISA relating to the benefits at issue. Dr. Clarke seeks appropriate equitable and injunctive relief under ERISA and applicable state laws, on behalf of his patients. With regard to the claims he asserts on behalf of other similarly situated health care providers, Dr. Clarke does not assert claims or seek any relief under any INET contracts with Defendants, but seeks only relief under ERISA on behalf of the patients the providers represent.

15. Plaintiff Leitz is a CIGNA Insured pursuant to a health insurance plan offered through her private employer. She resides in Weldon Spring, Missouri. Leitz challenges Defendants' denial of benefits and breaches of fiduciary duty under ERISA, and seeks similar appropriate equitable and injunctive relief under ERISA and applicable state laws.

16. The ACA, based in Arlington, Virginia, is the largest professional association in the United States representing Doctors of Chiropractic, with more than 15,000 members. The ACA promotes excellence in standards of ethics and patient care, contributing to the health and well-being of millions of chiropractic patients. On behalf of its members, ACA lobbies for pro-chiropractic legislation and policies, promotes a positive public image of chiropractic, supports research, provides professional and educational opportunities for Doctors of Chiropractic, and offers leadership for the advancement of the profession. The ACA's formal Mission Statement is as follows:

> The ACA is a professional organization representing Doctors of Chiropractic. Its mission is to preserve, protect, improve and promote the chiropractic profession and the services of Doctors of Chiropractic for the benefit of patients they serve. The purpose of the ACA is to provide leadership in health care and a positive vision for the chiropractic profession and its natural approach to health and wellness. On behalf of the chiropractic profession, we accomplish our mission and purpose by affecting public policy and legislation, by promoting high standards in professional ethics and quality of treatment and by carrying out a dynamic strategic plan to help ensure the professional growth and success of Doctors of Chiropractic.

17. As part of its work, the ACA assists members and patients who have been negatively impacted by improper insurance company policies and procedures, seeks to negotiate with insurers in an effort to advance the interests of chiropractors, and works with legislatures and regulators with respect to chiropractic legislation and regulations.

18. The ACA brings this action to obtain appropriate injunctive relief in enjoining Defendants' abusive practices as detailed herein.

THE DEFENDANTS

19. ASHN, a private corporation, is one of the nation's largest health services companies, providing claims administration and network management services on behalf of health plans insuring more than 20 million subscribers nationwide. ASHN contracts and

credentials its own network of more than 21,000 providers of chiropractic services located throughout the country. Among its clients, ASHN provides claims administration for chiropractic services for CIGNA. ASHN is headquartered at 10221 Waterridge Circle, San Diego, California 92121.

20. CIGNA Corporation is incorporated in Delaware. As reported in CIGNA Corporation's 2010 Form 10-K. CIGNA, through its Health Care segment (which it refers to as "CIGNA Healthcare") "offers insured and self-insured medical, dental, behavioral health, vision and prescription drug benefit plans . . . in all 50 states, the District of Columbia and the U.S. Virgin Islands." CGLIC is a subsidiary of CIGNA Corporation, licensed to do business in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Canada and Taiwan. The health insurance plans offered by CIGNA include those which insure the CIGNA Insureds for whom Dr. Clarke and many of the Association Plaintiff Members have provided healthcare services, as detailed herein. CIGNA's principal executive offices are located at Two Liberty Place, 1601 Chestnut Street, Philadelphia, Pennsylvania 19192. It also has corporate headquarters are located at 900 Cottage Grove Road, Bloomfield, CT 06002.

21. "CIGNA" is a brand name used for products and services provided by one or more of the CIGNA group of subsidiaries that offer, underwrite, or administer benefits. When used in this Complaint, "CIGNA" includes all CIGNA subsidiaries owned and controlled by any of the named Defendants whose activities are interrelated and intertwined with them. Due to the manner in which they function, including the discretion they exercise in making coverage determinations with respect to ERISA Plans, all of the Defendants are functional ERISA fiduciaries and, as such, they must comply with fiduciary standards.

JURISDICTION AND VENUE

22. CIGNA's actions in administering employer-sponsored healthcare plans, including determining reimbursement for providers who perform healthcare services to CIGNA Insureds pursuant to the terms and conditions of the healthcare plans, are governed by ERISA, 29 U.S.C. §§ 1001-1461. Plaintiffs assert subject matter jurisdiction for their ERISA claims under 28 U.S.C. § 1331 (federal subject matter jurisdiction) and 29 U.S.C. § 1132(e) (ERISA). The Court should maintain jurisdiction over the state law claims pursuant to the principles of supplemental jurisdiction.

23. Venue is appropriate in this District for Plaintiffs' claims under 28 U.S.C. § 1391 and 29 U.S.C. § 1132(e)(2) because: (i) CIGNA resides, is found, has an agent, and transacts business in this District, where its principal executive offices are located; (ii) CIGNA conducts a substantial amount of business in this District and insures and administers group health plans both inside and outside this District, including from offices located in this District, and (iii) ASHN administers healthcare plans and processes claims for services provided in this District, making coverage decisions while doing so.

DEFENDANTS' ERISA VIOLATIONS

24. CIGNA offers, underwrites, and administers employee benefit plans by and through which a number of CIGNA Insureds received their insurance. It is subject to ERISA, and its governing regulations. Further, due to the role CIGNA played in administering the Plans that insured the patients of Plaintiffs that are at issue in this matter, including making coverage and benefit decisions and deciding appeals, CIGNA assumed the role of a fiduciary under ERISA. In addition, due to the discretion ASHN exercised in making benefit determinations with regard to chiropractic services, ASHN similarly functioned as an ERISA fiduciary. Under ERISA, Defendants cannot deny coverage for health care services unless the applicable Plans expressly

include an exclusion that specifies that such services are not Covered Services, and Defendants further must act in the best interests of its subscribers in making coverage determinations.

25. Under ERISA, CIGNA is required, among other things, to comply with the terms and conditions of its Plans; to afford its Insureds or their Providers (through an executed authorization) an opportunity to obtain a "full and fair review" of any denied or reduced reimbursement; and to make appropriate and non-misleading disclosures to Plan Members 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 their interpretation of Plan terms; and providing appropriate data and documentation concerning its coverage decisions.

26. In offering and administering its Plans, CIGNA is the "Plan Administrator," as that term is defined under ERISA, because interprets and applies the Plan terms, oversees all coverage decisions (including by delegating such decisions to ASHN), and provides for payment to Plan Members and/or their Providers. As the Plan Administrator, CIGNA 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 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 Plan.

27. With respect to all of the health insurance plans issued by CIGNA, Defendants are obligated to CIGNA Insureds and their providers to provide specific, medically necessary, healthcare benefits and reimbursements. As detailed herein, Defendants are ERISA fiduciaries due to the discretion they exercise in making benefit determinations with regard to CIGNA Plans

and breached, and continue to breach, their obligations to Plaintiffs and the Class.

Manipulating Medical Records and Issuing False Benefit Forms

28. CIGNA delegated to ASHN the responsibility for administering chiropractic claims submitted by CIGNA Insureds or their health care providers. Pursuant to Defendants' requirements, once the Individual Providers provide health care services to CIGNA Insureds, they submit claims on behalf of their patients directly to ASHN. In these claims, Dr. Clarke and other health care providers identify by CPT Code (a five-digit number used to identify each individual health care service) the specific services they provided to their patients, along with their usual and customary charge for that service. ASHN is then responsible for processing the claim and either paying the provider directly or submitting it to CIGNA for payment.

29. Once a benefit has been determined, CIGNA issues an EOB to the CIGNA Insured which details the service, the billed charge, the amount deemed by Defendants to be covered under the health care plan (referred to as the "Allowed Amount"), any deductible or co-insurance which must be paid by the patient prior to any benefits being paid, and the amount of benefits paid to the provider on behalf of the patient. In addition, ASHN issues a Remittance Advice ("RA") to the provider, detailing the results of its claim processing.

30. The purpose of the EOB, required under ERISA, is to provide a complete and accurate summary of how the claim was processed, so that CIGNA Insureds and their providers will have a full understanding of the benefit determination that was made by Defendants. Moreover, by providing the necessary information, the CIGNA Insureds and/or or their providers will have the necessary information to appeal any denials or reductions of benefits, as permitted under ERISA.

31. In a blatant violation of ERISA, Defendants manipulated and falsified EOB's and other communications to providers and subscribers in order to distort Defendants' MLR. In

particular, while CIGNA entered into a contract with ASHN for ASHN to provide claims processing services in exchange for an administrative fee, Defendants issued false and misleading EOBs in order to hide the fact that such fees were improperly characterized as medical expenses.

Plaintiff Lietz

32. Plaintiff Lietz was repeatedly subjected to Defendants' false EOBs, leading to improperly increased out-of-pocket payments. On March 24-26, 2012, Lietz received chiropractic services from her provider, Inchiostro Chiropractic, Inc., which was INET with CIGNA and ASHN. Dr. Inchiostro then submitted a claim directly to ASHN on behalf of Lietz, for which he billed $160, for five separate services or modalities. On June 12, 2012, Dr. Inchostro received a remittance from ASHN which reflected that, based on the INET fee schedule, the "total allowed amount" was $88. It confirmed that the "claim paid amount" was that total, representing the amount that Dr. Inochostro was paid under his INET contract.

33. In contrast, Lietz received an EOB from CIGNA for the same services. Despite the fact that she had received services from Dr. Inchostro, the EOB represented that it was providing a "summary of a claim . . . for services provided by Amer Spec Hlth Cleaingh." This was false and misleading, as ASHN is ***not*** a health care provider and did ***not*** provide any services to Lietz.

34. The EOB then falsely reported that the "amount billed" was $127.28, stating that "this was the amount that was billed for your visit." That, too, was false. After reporting that there was no discount on the bill (which was similarly false), the EOB reported that the entire $127.28 was applied to Lietz's deductible and therefore "was paid from [her] Health Savings Account (HSA)." As a result, Defendants forced Lietz to pay $39.88 (or 45%) ***more*** than her

provider actually received for the services he provided. This discrepancy between the allowed amount and the patient responsibility indicates the administrative fee paid to ASHN, meaning that Lietz was forced to pay ASHN's administrative fee in addition to the provider's fee.

35. This is only one of numerous such examples experienced by Lietz, as the following summary demonstrates:

- For services received on 4/2-5/12, Dr. Inchiostro billed $130 and was paid, based on the INET fee schedule, $70 (as reported in a 6/4/12 remittance from ASHN); CIGNA issued an EOB to Leitz falsely reporting a bill of $101.24, all of which was paid from her HAS, or $31.24 (or 45%) ***more*** than her provider was actually paid.
- For services received on, respectively, 3/29/12, 4/11/12, 4/18/12, 5/4/12, 5/11/12, 5/18/12 and 5/29/12, Dr. Inchiostro billed $65 each time for spinal manipulation and mechanical traction, for which he was paid $35 pursuant to his INET fee schedule. Each time, CIGNA then issued an EOB to Lietz falsely reporting a bill of $50.62, all of which was paid from her HSA. Thus, Lietz paid out-of-pocket $15.62 (44.6%) ***more*** than her provider received for each date of service, or a total for all seven days of $109.34.

36. Because separate explanatory forms were sent to Lietz and her provider, they had no reason to suspect that Defendants were reporting different numbers or that Lietz was being charged more than her provider received. Only after Lietz raised the issue of the charges with her provider, did they discover what was happening.

37. After learning of the apparent discrepancy, Dr. Inchiostro emailed ASHN on September 18, 2012 to inquire, as follows:

> I am having our patients Health Reimbursement Account money being pulled out of their accounts by Cigna, sent to ASHN and then a lessor amount being sent to us by ASHN. When I called ASHN to inquire where the extra HRA funds were, I was told that ASHN and Cigna have a different fee schedule than ASHN and us, the provider's office, do. Which would lead me to believe that ASHN pockets this extra money that is above our fee schedule arrangement with them. The customer service rep I spoke with at ASHN (ref#: 8241047) told me to look at our contract with you and it should specify this in there. Well, I've looked through the whole thing and have not come across anything that explains why my patient's HRA money is being kept by ASHN instead of paying for qualified medical expenses. Could you please explain this to me in writing or link me to the place in our

> contract with you that is supposed to explain this, as the customer service rep stated. I would appreciate a prompt response to this matter as I and the patient are wondering where their HRA funds are ending up!

38. ASHN responded the next day, on September 19, 2012, with the following email:

> Thank you for your inquiry. I do apologize if the office was advised to check in contractual agreement for information that are not pertinent to the office. The contractual agreement between the office and ASH is: the office will be reimbursed at the fee schedule amount allowed by the Payor Summary, available under attachment G, section 2.0. Any other agreement between ASH and Cigna is confidential and will not be available in any written agreement between the doctor and ASH. If the member has any questions on how the HRA account is used, please refer the member to the Cigna Member service department.

39. This response by ASHN is patently inadequate, as it fails to address the fact that Lietz was forced to pay well more than the allowed amount paid to the provider, due to extra expenses paid to ASHN for its administrative services. This is directly contrary to the plan terms and ERISA.

40. While ASHN informed the provider that his patient could contact CIGNA with any questions, Lietz had not been provided with information that would raise questions, since any discrepancy between what Lietz was charged and what her provider actually received was not disclosed in the EOB. Moreover, since Defendants deem the agreement between ASHN and CIGNA which serves as the basis for the manipulated data included in the EOB is "confidential," any information sought by Lietz or other subscribers would be denied.

41. According to the Benefits Enrollment Guide provided to Lietz, her company's health care plan – issued and administered by CIGNA – "will continue to pay 80% of your medical expenses." As a means to reduce cost, the Plan encouraged Lietz and her co-workers to use INET providers since "you will save money," because there are "savings through lower rates for negotiated services" so that "you pay less in out-of-pocket expenses for care." As the Plan explains:

> **Protection against unexpected expenses above allowable charge –** network providers charge low, preferred rates well within the plan's allowable charges. An "allowable charge" is that portion of a medical or dental expense that is considered eligible for reimbursement under the medical or dental plan.

42. The Plan further describes how the deductible works, whereby a portion of the costs must first be paid by the subscriber before benefits under the Plan are paid: "The deductible is the amount you pay before the [Plan] pays for care other than preventive care. What you pay toward doctor's visits, prescription drugs and lab tests count toward paying your deductible." As an example, the Plan explains that, "assuming you have ***not*** met your plan's deductible," and the insured is treated for an illness by the doctor, "you pay the full cost of the visit (at CIGNA's negotiated rate)."

43. These provisions are violated by Defendants' actions with regard to its distorted EOBs. Any reasonable subscriber would read the Plan provisions as providing that the deductibles apply to what the ***provider*** is paid for services, based on "CIGNA's negotiated rate" with the provider. Nothing indicates that the subscriber will be responsible for ***more*** than the provider's allowed amount, based on the cost to CIGNA of its third party claims administrator, ASHN, which is never disclosed.

44. The Plan further explains how the HSA works to "help you pay for your healthcare expenses." As Plan explains, "you can use your HSA to pay for eligible medical expenses you incur at any time." Significantly, however, "eligible expenses are not limited to a specific calendar year," but HSA funds can be carried over from year to year if not used. This balance "accumulates on a pre-tax basis and accrues interest." Thus, the insured "will not lose any used money in your HSA (no 'use it or lost it' rule)," but the balance "carries over and builds from one year to the next," with the insured even able to bring the HSA account along if the insured changes employers. Since Defendants forced Lietz to pay too much from her HSA to

cover expenses beyond those actually incurred from her provider, Lietz was directly injured by their conduct. Such funds belong to Lietz and should be carried over from year to year, with interest, if they were not paid out improperly due to Defendants' ERISA violations.

Other Examples of Falisfied EOBs

45. Numerous other examples exist of falsified EOBs such as those experienced by Ms. Lietz. One chiropractor, for example, provided services to a CIGNA insured and submitted a claim for benefits reflecting his billed charges of $213. He subsequently received a "Remittance Advice" ("RA") from Defendants dated October 31, 2011 reflecting a "Total Billed Amount" of $213 and a "Total Allowed Amount," based upon his INET fee schedule, of $87. Since the latter amount reflecting the maximum amount that the provider could receive under his INET contract, that similarly represented the maximum amount that could be the responsibility of the patient. However, the RA misrepresented that the "Patient Responsibility" was $123.06, or well ***more*** than the provider was paid. Such a number was invalid and inappropriate.

46. CIGNA submitted an EOB to the patient. Rather than identifying the chiropractor as the provider of the services at issue, it falsely reported that it was a "summary of a claim for services . . . provided by Amer Spec Hlth Clearingh," or ASHN, even though ASHN was not the provider and provided no medical services. The EOB proceeded to report that the "Amount Billed" to be $123.06, which was also false, with that total amount "paid from [the patient's] Health Savings Account" ("HSA"). Thus, the patient here – as was true for Lietz – was forced to pay not only the $87 actually received by the chiropractor, as her provider, but also an additional $36.06 (or 41.4% of the allowed amount). Significantly, even though the provider had actually billed for four separate services, CIGNA failed to identify the separate services, but only reported a single charge, without identifying the actual services, in violation of ERISA.

47. Defendants disseminated similarly improper RAs and EOBs to numerous providers and their patients. In one such example, an INET ASHN provider billed $286, based on six separate services. In the ASHLink report to the provider dated September 26, 2012, it indicated that the amount allowed, and paid to the provider, was $144, based on the INET fee schedule. The patient's EOB, however, again identified the provider as ASHN, and reflected a total "Amount Billed" of $208.27, with that total amount applied to the patients' deductible, or 44.6% ***more*** than what the provider actually received, and taken out of the patient's HSA. Again, the patient was improperly charged the administrative fee for ASHN's services.

48. In another example, the provider inquired of ASHN, through ASHLink, how the patient could be held responsible for more than the amount billed by or paid to the provider. In response, ASHN replied as follows:

> Please be aware that the claim is originally processed by ASH and the services are priced according to the fee schedule, then forwarded to the health plan to have the member's benefit applied. The health plan will then apply the copay, coinsurance and/or deductible amounts based on their fee schedule and not ASH Networks Fee Schedule. This can sometimes result in the patient responsibility being higher than the ASH Networks Fee Schedule. ASH Networks reimburses providers at their contracted rates with the applicable member payments applied by the health plan. The amounts on the RA for copay, coinsurance, deductible, etc. will match the amounts the health plan has on the EOB's issued to the members. If the member disagrees with the patient responsibility applied to the claim by Cigna they will need to contact the Health Plan directly as they are responsible for that amount to your office.

49. ASHN therefore informed the provider that, under the policies as applied by CIGNA and ASHN, the patient was "responsible" to his office for more than his bill, creating an untenable situation that interfered with the doctor-patient relationship and created an undue burden on both the provider and his patients.

50. In responding to another such grievance filed by a provider, CIGNA explained its conduct as follows:

> Under ASHN's fee-for-service based arrangement with CGLIC, ASHN bills CGLIC for services provided by its contracted providers using the appropriate procedure codes for the services at rates agreed to between CGLIC and ASHN. CGLIC's payments to ASHN and the patient responsibility (e.g., co-insurance and deductible) are calculated based on ASHN's charged amount pursuant to the agreement between CGLIC and ASHN. The amount paid by CGLIC and the patient's responsibility equal the contracted rate agreed between CGLIC and ASHN.
>
> ASHN contracts with providers who elect to participate in its programs. CGLIC is not a party to the contracts between ASHN and its providers. The fee schedules attached to the contracts between ASHN and its network providers are not used in determining either CGLIC's payment to ASHN or the patient's responsibility. As such, the payment to the provider shown on the remittance advice does not serve as a way to calculate or verify the patient responsibility since the amounts are derived from different sources. ASHN has acknowledged that this is confusing and has worked with CGLIC to enhance the remittance advice document to make it easier to understand.

51. Notwithstanding CIGNA's representation that the billing discrepancy was merely "confusing," the fact is that Defendants' actions are improper and in violation of law. Defendants' policy, as explained in the letter and demonstrated in the examples given above, permits Defendants to misrepresent the administrative fee CIGNA pays to ASHN for purposes of calculating benefits, including what portion is to be paid to the providers and what portion is the responsibility of the patient.

52. Under the CIGNA Plans, however, patient responsibility is to be determined as a function of the portion of the bill ***from the provider*** which is deemed to be covered under the Plan, not to the administrative fee charged by ASHN. Moreover, by treating ASHN's administrative fee as medical expenses, Defendants are in violation of the new health care law and its underlying regulations.

53. ASHN's explanation demonstrates that, while the provider is paid based on a fee schedule issued under his INET contract with ASHN, CIGNA nevertheless uses a second and undisclosed fee schedule for purposes of determining benefit claims, including patient

responsibility. This differential reflects the addition of the administrative fee that CIGNA owes ASHN, which means that Defendants are improperly treating the ASHN administrative fee as part of the medical expenses, in violation of federal regulations.

54. These providers' experiences are hardly unique, but represent only a handful of numerous times in which Defendants falsified their reported claims processing.

55. In one such example, a provider submitted a claim to Defendants for chiropractic services to a CIGNA Insured in October 2011. The claim indicated that the provider had billed a total of $68 for the services he provided. After ASHN processed the claim, an RA was sent to the provider which reported the “Total Amount Billed” as $68 and the “Total Allowed Amount” as $61.88. That Allowed Amount reflected the total amount that ASHN had determined based on the provider’s INET contract. Under the terms of CIGNA’s plans, the Allowed Amount represented the total amount that CIGNA could be responsible for paying in benefits, less any applicable deductibles or co-insurance owed by the Insured. Pursuant to the INET contract, providers would generally be precluded from balance billing patients for the difference between the billed charges and the Allowed Amount.

56. Under the CIGNA Plans, the CIGNA Insureds are usually responsible for some portion of the health care bill. This can include a “deductible,” which represents an amount the CIGNA Insured must pay toward covered health care expenses before CIGNA (or its agent, ASHN) is responsible for payment, or “co-insurance,” represents a portion of the allowed amount which must be shared by the CIGNA Insured (usually 20%). Thus, with the Allowed Amount of $61.88, that should be the maximum amount that would be paid by the CIGNA Insured, if all of it fell within the deductible, or some portion reflecting a combination of the deductible and co-insurance. Despite the fact that the Allowed Amount reported in this RA was

$61.88, however, the RA reflected that the "Patient Responsibility" was $87.52, or nearly $20 ***more*** than the ***billed*** charges. This is in direct violation of the CIGNA Plan terms which limit the Patient Responsibility to some portion of the Allowed Amount for an INET provider. Because the CIGNA Insured was purportedly responsible for an amount greater than the Billed Charges or the Allowed Amount, the RA reflected that nothing was paid to the provider.

57. As with the other examples provided, the EOB submitted to the CIGNA Insured again listed ASHN as the provider, falsely indicating that ASHN itself was responsible for providing the health care services and creating a means by which CIGNA could falsely record inflated payments made to ASHN rather than the actual payments made to providers as medical expenses for purposes of the MLR. The EOB also falsely reported that that the "Amount billed" was $87.52, compared to the actual billing of only $68, as reported in the RA, with the falsely reported billed amount of $87.52 then identified as the "Covered Amount" under the Plan.

58. Not only was this untrue, as the actual billed charge was $68, while the Allowed Amount was $61.88, but it falsely indicated that CIGNA had given the full credit to the billed charge for the Allowed Amount and that CIGNA had authorized $87.52 in medical expenses, which it had not. CIGNA then applied the entire $87.52 to the patient's "Copay/Deductible, along with the following explanatory note: "After you have met your deductible, the cost of covered expenses are shared by you and your health plan. The percentage of covered expenses you are responsible for is called coinsurance." As a result, even though the Allowed Amount for purposes of the provider was only $61.88, CIGNA allocated $87.62, or nearly $18 more, to the patient's deductible, and paid the provider nothing.

59. Among other things, the Defendants' conduct, as demonstrated through their RA and EOB, forced the provider to balance bill the patient or, in cases where balance billing is

contractually prohibited, to take a loss, and could lead patients to going out-of-pocket quicker and making false tax filings if taking medical deductions. At the same time, it put the provider in a quandary, as Defendants' documentation to the patient asserted that the patient owed more than the provider had even billed. Further, by imposing inflated obligations on the CIGNA Insureds, they used their HSAs to pay unknowingly for administrative fees or unknowingly submitted false claims for reimbursements to their secondary carriers.

60. Similar examples abound, including the following:

- An RA reflects that the provider billed $87, with the allowed amount being $38. The patient responsibility should therefore have been no more than $38, representing the amount that the provider was allowed under his INET contract. However, the "patient responsibility" is reported to be $53.75, or $15.75 ***more*** than the allowed amount, so that the provider receives no payment from ASHN/CIGNA. The EOB sent to the patient by CIGNA misrepresents the provider as ASHN, and then shows the "amount billed" and the "covered amount" as $53.75. This entire amount is then allocated to the patient as a "copay/deductible." The EOB is false in that the amount billed was actually higher and the covered amount was lower, such that the patient responsibility should similarly have been lower.

- A provider billed $47, with $25 identified as the allowed amount in the RA, but the patient responsibility is identified as $30.27, or $5.27 ***more*** than what the provider is to be paid under his INET agreement;

- A provider billed $63 and the allowed amount in the RA was identified as $26. The patient in this case had satisfied his deductible and owed a 20% co-payment, which would have been $5.20, so that the provider should have been paid $20.80. Instead, the RA reported that the patient's co-insurance was $6.36, so that the provider was only paid $19.64, or $1.16 too little;

- A provider billed $50, which also was the allowed amount, but the RA then indicated that the total "non-allowed amount" was $70.52, or $20.52 ***more*** than the billed charges;

- A provider billed $68, with the allowed amount being $61.88; although the patient had a 10% co-insurance, which would have meant he was responsible for $6.19, the RA reflected that the patient was responsible for $8.76. The provider was only paid $53.12.

61. In each example, the amount attributable to the patient is higher than it should be as a result of Defendants' mischaracterization of the billed and allowed charges. By manipulating

the information, Defendants are able to present information to the patient that indicates that the medical expenses are actually higher than they are, in violation of ERISA.

62. Section 2718 of the Public Health Service Act ("PHSA"), 42 U.S.C. 300gg-18 as amended by the PPACA, requires that health insurers such as CIGNA report on major categories of how they spend premiums. As part of these MLR requirements, the law mandates that insurers rebate subscribers when the percentage of premium dollars spent on medical costs is below a floor, 80% or 85%, depending on the type of plan at issue. In determining the MLR, the insurer may include both the actual costs spent for medical expenses as well as for those which are designed to improve health care quality for subscribers.

63. The Department of Health and Human Services ("HHS") issued an Insurance Standards Bulletin on July 18, 2011 to provide guidance regarding the calculation of MLR as it relates to payments made to third party vendors. That Bulletin contained the following question and answer:

> Q. How should an insurer report amounts paid to third party vendors who pay others to provide clinical services to enrollees and who perform network development, administrative functions, claims processing, and utilization management?
>
> A. In general, an issuer may only include as reimbursement for clinical services (incurred claims) the amount that the vendor actually pays the medical provider or supplier for providing covered clinical services or supplies to enrollees. Where the third party vendor is performing an administrative function such as eligibility and coverage verification, claims processing, utilization review, or network development, expenditures and profits on these functions would be considered a non-claims administrative expense as provided in 45 CFR §158.140(b)(3)(ii).
>
> Some third party vendors provide reimbursement for clinical services to enrollees and provide administrative functions such as claims processing and network development. Payments by an issuer to a third party vendor to provide clinical services directly to enrollees through its own employees are considered to be incurred claims. However, the amounts paid by the issuer to a third party vendor for the functions that are not direct clinical services to enrollees through its own

> employees are governed by §158.140(b)(3)(ii), and only the amounts the third party vendor pays to providers may be included in incurred claims. . . . The amounts attributable to network development, administrative fees, claims processing, and utilization management by the third party vendor and the third party vendor's profits on those activities must not be included by an issuer in its incurred claims.
>
> For example, when a pharmacy benefit manager (PBM) pays a retail pharmacy one amount for prescription drugs covered by the plan and charges the issuer a higher amount (the retail spread), the issuer may only claim the amounts paid by the PBM to the retail pharmacy as incurred claims.

64. ASHN is a third party vendor that falls within the July 18, 2011 Bulletin. As a result, when CIGNA reports its MLR, it is precluded from including the administrative fees paid to ASHN for claims processing and utilization management as part of the medical expenses which would be included in the MLR.

65. The Department of Labor issued its Interim Final Rule with respect to the MLR rebates on December 2, 2011 (45 CFR Part 158). The Rule specifies that premium rebates are considered to be plan assets under ERISA. Because any party with authority or control over plan assets is an ERISA fiduciary, any action with respect to a rebate under the MLR requirements is a fiduciary action.

66. Various state laws similarly established minimum MLRs. The California Insurance Code, for example, gives the California Insurance Commissioner explicit authority to withdraw approval of an insurance policy in that state if, "after consideration of all relevant factors, . . . the benefits provided under the policy are unreasonable in light of the premium charged." Cal. Ins. Code § 10293. State regulations specify that one factor in considering whether benefits are reasonable in relation to the premium charged is whether the medical benefits provided under a policy account for at least 70% or more of the premiums collected. Cal. Admin. Code tit. 10, § 2222.12. This calculation is supposed to be based on an analysis of actual loss experience.

67. Based on information and belief, Defendants' scheme in manipulating its medical records and distorting its claim forms is based on its effort to falsely increase the medical expense portion of the MLR by improperly characterizing the administrative fee it pays to ASHN as part of the reimbursement for services rendered. In doing so, Defendants underpay the providers and overcharge the subscribers. In each example provided herein, Defendants had inflated the amount of patient responsibility, apparently reflecting the amount CIGNA pays in administrative fees to ASHN. Nothing in CIGNA's Plans disclose or permit it to pass these costs to its Insureds or their providers. Indeed, the scheme requires Defendants to falsify medical records by misstating billed and allowed amounts, and issuing EOBs with inaccurate information. Such conduct is improper and in violation of ERISA, as detailed herein.

68. By falsifying the records to reduce the reported billed amounts and inflating the reported Allowed Amounts, CIGNA is also able to falsify reports of billed charges which it may provide to governmental or outside agencies which collect information for purposes of reporting usual, customary and reasonable ("UCR") rates. In February 2009, for example, CIGNA entered into an agreement with the New York Attorney General, whereby it agreed, *inter alia*, to pay $10 million toward the creation of "a new, independent database run by a qualified nonprofit organization" for the purpose of reporting UCR rates for health care services. CIGNA and other insurers would contribute their own charge data to the new entity, which would be "the sole arbiter and decision-maker with respect to all data contribution protocols and all other methodologies used in connection with the database," and it would "make rate information from the database available to health insurers" for use with health care plans that set out-of-network reimbursement based on UCR. The validity of the new database, however, was dependent upon receiving accurate information as to what providers actually charged in the open market for their

services. Yet, by altering the actual charges in its EOBs and other communications, CIGNA falsely billed rates well below the actual charges, therefore allowing it to underreport UCR data.

69. When the New York Attorney General announced its agreement with CIGNA, he was joined by CIGNA officials. A CIGNA representative stated at that time:

> Cigna commends the Attorney General's efforts to bring greater transparency to the pricing of health care services and we are pleased to partner in the creation of an independent not-for-profit organization to administer the new database. We recognize the attorney general's concern that there are inherent conflicts of interest related to the Ingenix database and expect that this new database will further enable people to make informed choices about their health care purchases.

70. Despite this public representation that CIGNA supported an accurate and "transparent" database to reflect true UCR rates, CIGNA has, in fact, acted to distort such data, to the detriment of health care providers and subscribers, in violation of ERISA.

Pre-Certification Requirements

71. The standard CIGNA Plan provides CIGNA Insureds with coverage for chiropractic services, with a set limit on the total number of available office visits per year (*i.e.*, 20 or 30 visits). However, the standard Plan does ***not*** require that CIGNA Insureds obtain pre-authorization prior to receiving services, with the only limit on care being that CIGNA is entitled to evaluate the medical necessity of the service on a retroactive basis, as is true for any health care services provided pursuant to a health benefit plan.

72. This policy is reflected in CIGNA's precertification policy reported on its website. With respect to CPT Codes 98940, 98941, 98942 and 98943 (chiropractic manipulation services), for example, CIGNA specifically reports that these procedure codes do "not require precertification when performed as an outpatient procedure by a CIGNA participating provider," adding for Out-of-Network ("OON") providers that "the member's plan ***may*** require that these services be precertified" (emphasis added), referring the reader to the number listed on the ID

card. This latter disclosure demonstrates that pre-certification is also not required for OON services under at least some CIGNA plans. Moreover, in a section on its website entitled "Member rights: Understanding your health benefits FAQs," CIGNA states that for "[a]ll specialty services," which would include chiropractic care, "[p]rior approval by CIGNA is not required for these types of services." Thus, to the extent CIGNA considers chiropractic care to be "specialty services," its reported policy is not to require any prior approval.

73. Similarly, in a "Plan Comparison Grid" which CIGNA provides on its website to summarize the type of coverage provided under its various plans, it lists chiropractic care, stating that "[b]enefits [are] provided through contracted chiropractors in ASH Plans Network." It then summarizes the available benefits under the various plan types as being responsible for between $15 and $20 copays, with 20-30 visits per year allowed, adding: "You may see any provider when you need care. You decide whether to see a network or an out-of-network provider each time you need care." These disclosures make clear that generally there are ***no*** precertification requirements in the CIGNA Plans for chiropractic services, but, rather, that the CIGNA Insureds are entitled to see any provider they choose when they need care, up to the specified number of annual visits.

74. This conclusion is reinforced by the provisions in CIGNA's standard plans. In one such plan, for example, it explicitly states: "TRS Care covers a maximum of 20 visits per plan year. ***Precertification is not required***" (emphasis added).

75. Another standard CIGNA Plan, which has a Certificate of Coverage issued by CIGNA Health Inc., in Florida, provides explicit coverage for chiropractic services, stating:

> The following services are covered without a referral when rendered by a Participating Provider. . . . Direct Access to Chiropractors. Benefits are provided to Members for chiropractic services performed by a Participating Chiropractor limited to office visits, minor procedures and testing. The number of visits, if any,

is listed on the Schedule of benefits.

76. The Plan further details coverage for subluxation benefits, stating:

> Subluxation Benefits – Services by a Participating Provider when Medically Necessary are covered. Services must be consistent with [CIGNA] guidelines for spinal manipulation to correct a muscular skeletal problem or subluxation which could be documented by diagnostic x-rays when performed by an [CIGNA] Participating radiologist. Coverage is subject to the maximum number of visits, if any, shown on the Schedule of Benefits.

77. The CIGNA Plan issued to Plaintiff Leitz and other enrollees in the State of Missouri provides that such Plan implicitly and specifically adheres to the laws of the state. Such laws provide for the following:

> An enrollee may access chiropractic care within the network for a total of twenty-six chiropractic physician office visits per policy period, but may be required to provide health carrier with notice prior to any additional visit as a condition of coverage.

78. CIGNA, through ASHN, has required pre-certification of chiropractic physicians prior to the 26 visit mandate, in violation of the Missouri law which has been made part of its contracts with its enrollees. Finally, the Plan makes clear that chiropractors performing with the scope of their license fall within the definition of "physicians" for purpose of the coverage of health care services:

> Physician. A duly licensed member of a profession, who has an M.D. or D.O. degree, who is properly licensed and certified to provide medical care under the laws of the state where the individual practices, and who provides Medical Services which are within the scope of the individual's license or certificate. This definition includes . . . chiropractors . . .

79. Based on these provisions, it is self-evident that CIGNA Insureds who participate in such Plans are not required to have their care for chiropractic services pre-authorized, but they may instead go directly to a chiropractic provider for the number of visits authorized under the Plan's Schedule of Benefits. Further, the Plan reveals that it covers all medically necessary, evidence based, services that chiropractic physicians can provide that fall within their scope of

practice, thereby precluding other limitations on coverage imposed by Defendants.

80. In sharp contrast to the CIGNA Plans, Defendants, through the imposition of ASHN's policies, have established a scheme whereby they have imposed constructive pre-authorization requirements ***on the providers*** and thereby secretly imposed such requirements on CIGNA Insureds, without ever disclosing that fact to them. After all, if a CIGNA Insured goes to a provider who CIGNA requires to obtain pre-authorization prior to providing services, then that means that the patient's services are subject to such pre-authorization requirements, even though that is explicitly precluded under the applicable Plan.

81. According to ASHN's written policies, all chiropractors "are required to submit documentation for verification of Medical Necessity for all services after the initial evaluation of a patient." Despite ASHN's reference to "verification of Medical Necessity," what this means in practice is that ASHN requires pre-authorization of such services, as it will not cover services that are not submitted for review. To obtain pre-authorization for services, chiropractors must submit a "Clinical Treatment Form" ("CTF") to ASHN. However, ASHN permits chiropractors to obtain a "Treatment Form Waiver," which allows them to avoid many of the aggressive pre-authorization requirements "based on their level of compliance with professionally recognized clinical standards approved by ASH clinical committees (ASH standards)." In fact, ASHN's policies are inconsistent with "professionally recognized clinical standards."

82. During the first part of the Class Period, as defined herein, ASHN required that, after the completion of five treatments, all chiropractors must submit a treatment plan for pre-authorization. In an April 28, 2010 email from an ASHN employee to a provider, for example, ASHN stated: "[C]laims should be sent to ASH for this member. . . . ASH approval is required for visits beyond the 5th visit in a calendar year."

83. This policy is reinforced in an internal ASHN memorandum dated December 30, 2004, summarizing the Treatment Form Waiver Program, which states:

> [American Specialty Health Affiliates (ASHA)] utilizes a Treatment Form Waiver Program (TFWP) for contracted practitioners that defines appropriate levels of quality and clinical services management based on peer reviewed clinical and administrative criteria. The program allows certain clinically necessary treatment/services to be rendered prior to evaluation of medical necessity by ASHA. If the member requires more treatment/services than are available at the practitioner's Treatment Form Waiver level, the practitioner will submit a Clinical Treatment form for verification of medical necessity of those additional treatment/services by a clinical services manager. Post-service review may also be performed at any time for any ASHA member.

84. As this clearly establishes, the program is designed to impose "verification of medical necessity" ***prior*** to the service being provided, which means it constitutes a pre-authorization requirement. Such a requirement, however, is inconsistent with the terms and conditions of the CIGNA Plans which do not require such pre-approval.

85. To establish at what point in the treatment process a provider is required to obtain pre-authorization for chiropractic services, ASHN has adopted a tiering policy designed to pressure chiropractic providers to offer reduced treatments to their patients. Under ASHN's policy, chiropractors are placed within one of six tiers. Tier 1 requires a provider to submit all claims for pre-authorization after the initial exam; Tier 2 requires it only after the first five visits, except for x-ray procedures, which require pre-authorization immediately; Tier 3 requires it only after the first five visits, including x-rays; Tier 4 requires it only after the first 8 visits; Tier 5 requires it only after the first 12 visits, plus allows two standard office exams, with x-rays; and Tier 6 requires no pre-authorization submissions at all. While ASHN characterizes its policies as solely relating to "verification of medical necessity," and not pre-authorization, that is mere nomenclature. At its heart, the tiering process establishes clear requirements that providers obtain pre-authorization from ASHN prior to performing and/or billing for health care services to

CIGNA Insureds.

86. ASHN's requirements are not found in the CIGNA Plans, nor do they follow customary industry practice. Rather, these requirements are provider-specific, based on utilization, and are predicated upon providers treating patients in the manner ASHN predetermines. For example, if a provider has a series of complex patients present for treatment, the provider's averages may be higher than the overall network average, causing ASHN to place the provider on a lower tier. This would require all the provider's treatment plans to be preauthorized, which would therefore delay and interfere with the delivery of care to the provider's patients.

87. In addition, the tiering process adopted by ASHN ties the provider's performance (according to ASHN's standards) to what care will be permitted for a particular patient. This makes patients eligible for differing amounts of care based on the provider they choose and not based upon standard protocols of medical necessity determinations, which is contrary to the Plan terms. For example, should a patient need care beyond the TFWP period, the treatment authorized is often fifty percent or less than the requested amount. Therefore, the care ultimately allowed is less for a patient seeing a provider on a lower tier than seeing a provider at a higher tier. Because of this, ASHN's tiering program effectively alters the Plan benefit without patients' knowledge. Moreover, since the tier to which a doctor is assigned can often limit the care to the patient, it also can impact the outcome of treatment. This is demonstrated in the following example:

	Doctor's Tier	**Initial Visits Provided**	**Additional Request/Amount Granted**	**Total Visits Patient Received**
Patient #1	Tier 1	1	8/4	**5**
Patient #2	Tier 6	7	2/1	**8**

88. To determine in which Tier to place a particular chiropractor, ASHN examines the average numbers of different treatments that a chiropractor provides to their patients, as well as their compliance with various ASHN treatment guidelines. In order to fall within any of the Tiers other than Tier 1 (*i.e.*, to avoid having to obtain pre-authorization for any services after the initial office exam), ASHN requires chiropractors to average less than 6.5 visits per patient per year. To be placed in Tiers 4 through 6, requiring the least amount of oversight and pre-authorization reviews, the chiropractor must average less than 7.5 visits per patient in any one review period, with the chiropractor to be reduced by one Tier if the average visits are more than 7.0 visits for two consecutive review periods. For Tier 5 or 6 providers, they will be reduced down to Tier 3 if their average number of visits is greater than 9, and any provider with an average number of visits more than 11 is placed in Tier 1. ASHN also has specific provisions relating to x-ray utilization. If, for example, providers use x-rays on more than 60% of patients (out of a minimum of 40), if 10% of all patients receive multiple sectional views, or if 5% receive full-spine x-rays, they will be assigned to Tier 2. Extenuating circumstances are not considered by ASHN, such as a chiropractor seeing a disproportionate number of elderly patients, or patients with severe or chronic conditions; or chiropractors with a specialization in a field, such as rehabilitation.

89. In justifying why it sets the 6.5 average office visit per patient per year as the standard for its tiering requirements, ASHN states that "[t]his is consistent with ASH's national chiropractic provider network data for average visits per patient per year," such that "it is reasonable to use this 6.5 visit average per patient per year as a criterion for the point above which standard clinical oversight of utilization is performed." The explanation is flawed and inadequate. ASHN has insufficient data to justify its use of this limit, and to the extent it uses its

own data, it is improper as those rates have been artificially reduced by ASHN's pressure on its chiropractors to reduce the number of office visits they provide, in effect continually skewing the number of allowed visits downward over the past several years.

90. The extreme pressure placed on providers to "perform" at their levels is also detrimental to patient care because it incentivizes providers to provide the first five visits and discontinue billing, to convert the patient to a self-pay status, or to refer the patient to another provider to obtain necessary care. To request more visits/treatments from ASHN is to risk having the request rejected, which adversely affects the provider's rating, and also sends the message to patients that they don't need any further care and/or their provider is not correct in his assessment of their clinical need. Notably, the care provided after the fifth visit is not in ASHN's computers in the above scenarios, so ASHN does not have the capability of determining the actual amount of treatment required for the diagnoses treated by the providers in its network. This fact renders the performance averages to which they hold providers meaningless in their Tiering Program.

91. As for why ASHN set five visits for other portions of its tiering policies, ASHN states that "[f]ive visits was chosen as the initial threshold since greater than 50% of patients in the ASH system use five or fewer visits based on the current claims data." This data is, again, distorted and taken out of context, and is not in keeping with standard chiropractic protocols or what is taught in chiropractic colleges. It also does not justify imposition of pre-authorization requirements, particularly when they are not part of the patient's health care plan.

92. CIGNA Insureds are not informed even of the existence of ASHN's tiering policies, let alone of the Tier level at which their provider is placed. Yet, the ASHN policies mean that when CIGNA Insureds choose to go to a chiropractor, their services may well be

subject to pre-authorization, even though such oversight is expressly not required under the applicable health care Plans. As a result, whenever pre-authorization is imposed on CIGNA Insureds, as a result of the Tier at which their providers are placed, Defendants have violated ERISA.

93. In addition to the tiering policies imposed on INET providers, Defendants applied similar requirements on OON providers. In a December 2011 announcement to Tennessee chiropractic physicians, for example, CIGNA stated that it had "expanded [its] relationship with American Specialty Health Networks, Inc. (ASHN Networks) effective April 1, 2010 to administer out-of-network benefits for chiropractic services to patients with CIGNA coverage," thereby "implementing utilization management for out-of-network services through ASH Networks." This policy included the following:

> Verification of medical necessity for all services rendered by non-participating chiropractors is required under this program. Non-participating chiropractors will be asked to provide information necessary to conduct a determination of medical necessity, after the 5th visit, with a patient who has out-of-network benefits. The chiropractor should render all necessary services but reimbursement will be limited to those covered services determined to be medically necessary through the ASH Networks evaluation process. Any services not approved for reimbursement by ASH Networks will be the patient's responsibility.

94. Under ERISA regulations, 29 C.F.R. § 2560.503-1, "a claim for benefits is a request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims," and "a claim for benefits includes any pre-service claims." Pre-service claims are then defined as "any claim for a benefit that is conditioned, in whole or in part, on approval of the benefit in advance of obtaining medical care."

95. ASHN's policies with regard to chiropractic claims constitute "pre-service claims" under ERISA, in that they condition the coverage for the chiropractic services on ASHN's approval. This is confirmed by ASHN's own summary of its policies. In a Q&A

prepared for providers by ASHN, for example, it describes a "Treatment Form Waiver" as "a specified number and types of services that are reimbursable without submission of a Clinical Treatment Form (CTF) to ASH." Thus, services that are not subject to the waiver – and therefore requiring submission of the CTF – are not "reimbursable." Moreover, ASHN states that "[o]nce a Clinical Treatment Form has been submitted, all dates of service covered by or after the approved treatment plan period will not be eligible under the Treatment Form Waiver," further reflecting that coverage is dependent on the submission of the CTF.

96. This is further verified in a September 2011 email in which an ASHN employee responded to a chiropractor's inquiry concerning pre-certification requirements by saying:

> There is no pre-certification required for "chiropractic claims". There is a process required for verification of medical necessity for the treatment intervention under consideration. The requirement for submission of a Clinical Treatment Form (CTF) is required following the 5th visit. In other words, the patient may present for care for 5 visits and the practitioner essentially treats and submits the claim for payment. Following the 5th visit the provider is required to submit the CTF for additional care. The requirement for submission varies, depending on the provider's tier level. . . .

97. Notably, while ASHN represented that no pre-certification requirement was being imposed, this is belied by its explanation that, following the 5th visit a chiropractor must "submit the CTF for additional care." This ***is*** a pre-certification requirement.

98. As an OON provider, Dr. Clarke has not agreed to comply with any of Defendants' internal policies relating to the provision of chiropractic services, so that he – on behalf of his CIGNA Insured patients – is entitled to receive all benefits otherwise available under the applicable CIGNA Plans without regard to other policies adopted by Defendants. Nevertheless, CIGNA has imposed the same cumbersome and burdensome obligations on them for providing services to CIGNA Insureds, as well as pre-certification requirements which are in violation of CIGNA Plan provisions. Defendants use these requirements to deny or reduce

benefits to CIGNA Insureds improperly.

99. This oversight imposed on OON providers is not detailed in the CIGNA plan documents. To the contrary, the Plan documents strongly imply that OON providers avoid such oversight, which is why it costs more for the subscriber.

100. Defendants impose such requirements on OON providers in a deliberate effort to make it more difficult for them to treat CIGNA Insureds, so as to pressure them into either joining the CIGNA network or cease treating CIGNA subscribers altogether.

Dr. Clarke

101. Dr. Clarke has treated a number of CIGNA Insured patients who have been subjected Defendants' policies which are at issue in this case. From those patients, Dr. Clarke has obtained a standard Assignment of Benefits form, which states:

> I authorize payment of medical benefits to High Street Rehabilitation, LLC for all services rendered. I understand that I am financially responsible for all charges whether or not they are paid by insurance (commercial, worker's compensation, auto, etc.). In the event of an unpaid balance, I am aware that my bill will be sent to the collection agency and that I will be held responsible for any and all charges incurred, including attorney fees.

102. Based on those assignments, Dr. Clarke submits claims directed to Defendants as an OON provider, on behalf of CIGNA Insureds. Upon doing so, ASHN regularly requires him to provide back-up documentation through a CSF to justify the services. With regard to one patient, for example, he submitted a CSF on May 11, 2012, with regard to six office visits, along with 11 separate therapies, he had provided in March 2011. The next day, on May 12, 2012, ASHN returned a Response Form in which it limited approval to the five sessions it allows under its policies, thereby excluding one, while also limiting the number of requested therapies to two per session, or a total of ten, one below the amount provided.

103. The Form identified the Clinical Services Manager to be "J. Greene, M.D." It further stated: "In order for services to be Covered Services, they must be medically necessary. All medical necessity determinations are made by appropriately licensed Clinical Services Managers." No further information was provided as to what license Dr. Greene had or what, if any, training or experience in chiropractic services she had received prior to making a coverage determination with regard to chiropractic services.

104. In justifying its conclusion that only five sessions should be approved, ASHN stated:

> We reviewed your clinical information such as your history, pain levels, ability to do your daily activities, evaluation findings, and treatment plan. We only approved as covered services 5 visits to be used from 03/08/2011 to 03/23/2011. We have determined that 5 office visits from 03/08/11 to 03/23/2011 is enough to either completely treat your condition or take you to a point where your progress should be re-assessed.

105. As for the reduction of approval for the therapies from 11 to 10, ASHN stated:

> THERAPIES APPROVED IN PROPORTION TO THE NUMBER OF OFFICE VISITS APPROVED: Of the 11 therapies submitted for review by your provider, Steven Clarke, D.C., we approved for payment 10 therapies. The number of therapies is in direct proportion to the 5 office visits that were approved for payment.

106. As this statement makes clear, ASHN did not deny the one therapy based on any analysis for evaluation of the medical necessity of that particular therapy. In fact, it did not deny a particular therapy, but rather issued its denial based solely on the ***number***, limiting the total to two therapies per approved office visit. It did so notwithstanding the fact that there is no such limit to the number of therapies performed in the underlying plan terms, nor is there any justification based on generally accepted medical standards to limit treatments only to two therapies per office visit.

107. Based on information and belief, ASHN did not undertake any analysis of the actual report by Dr. Clarke, or the underlying medical records, in limiting the number of office visits to five and the number of therapies to two per visit. Instead, ASHN merely applied in a uniform and systemic way its undisclosed policy limiting coverage to five sessions, and two therapies per session, policies which are never disclosed or included in the underlying plan documents. The fact that Dr. Clarke had only provided six office visits highlights this point, since it is not reasonable to believe that ASHN had a legitimate basis to conclude on the records that five sessions were medically necessary, but not six. Similarly, ASHN had no legitimate basis for denying one therapy when it didn't even apply this to a particular service or undertake a medical necessity evaluation of such service.

108. On May 14, 2012, Dr. Clarke submitted a $200 claim to ASHN for services provided to another CIGNA Insured patient on May 4, 2012. In response, ASHN refused to pay the claim, but instead requested back-up documentation, stating:

> ASH received a claim submission on 5/14/2012, which is identified above. Additional information is necessary in order to complete the processing of this claim. All services submitted on this claim ***and future claims*** must be verified as medically necessary services in order for those services to be eligible for reimbursement. ASHN is requesting from the rendering provider the information necessary to verify medical necessity to the services pertaining to the claim indicated above.

109. ASHN then detailed the steps an OON provider must follow "to verify the medical necessity of services:

- Complete a simple **OON Medical Records Cover Sheet** identifying the services submitted for review and the timeframe during which those services are to be delivered; and
- Submit either a **Clinical Information Summary Sheet** or medical records including, at a minimum, the following elements:
  - **OON Medical Records Cover Sheet** . . .

- **History and Evaluation information** including sought care for, how it began and any pertinent Examination/Evaluation Forms.

110. Significantly, ASHN was not demanding this information after the fact, but also for ***future*** services, as it added:

> We are encouraging the provider to submit for review not only for the services on the claim indicated above but also any other services or dates of services rendered ***and/or anticipated to be rendered over the next 30-60 days.*** This allows for a coverage determination and prevents future delays in claim processing. Getting services verified as medically necessary in this manner informs the member and provider what services are eligible for reimbursement and the services for which the member may be financially responsible.

111. In an "Out-of-Network Information Packet" provided to Dr. Clarke for providing services to CIGNA Insureds, ASHN stated, in order to obtain verification of medical necessity, he would "need to tell us what dates of service . . . and what services you want us to review (number of dates of service, manipulation services, adjunctive therapies, x-rays, etc.)," adding that ASHN "needs clinical information supporting the patient's diagnosis and your treatment plans." ASHN then stated that the Clinical Information Summary Sheet was provided "as a convenience to you to help ensure all necessary information is included in your response," but that the OON Medical Records Cover Sheet still needed to be used "if you choose to submit medical records."

112. In explaining the scope of ASHN's policy, it stated that it applied to all CIGNA Insureds "with CIGNA managed care medical benefit plans (e.g., Commercial HMO, Network, POS, Open Access, Open Access Plus, and PPO)." Further, ASHN stated that, with regard to "medical necessity review," "to be eligible for reimbursement this plan requires verification of medical necessity for all services performed by out-of-network providers after the fifth (5^{th}) visit per member per calendar year."

113. In essence, the ASHN policy with regard to OON services is identical to what INET providers are required to do pursuant to their contracts, plus the additional cumbersome requirement of providing medical records for each and every service after the first five. None of these requirements are disclosed or explained in the plan documents, where CIGNA Insureds are offered an OON option to obtain services from OON providers without such restrictions on coverage.

114. In compliance with ASHN's requirements, Dr. Clarke submitted his medical records report for one date of service to the CIGNA Insured on May 4, 2012, with two modalities. According to Dr. Clarke's medical records, the patient was suffering "persistent active complaints to the neck into the left upper extremity which has failed interventional treatment including facet blocks and epidurals." The records further reflected that the patient at times "has been completely dehibilitated and unable to get pain relief." Dr. Clarke stated that, based on this treatment and evaluation of the patient, that "the modalities and procedures were used to help facilitate her recovery." He then concluded that she was "progressing as expected," and that, while "this is a long term chronic condition," he "expect[s] gradual symptomatic and functional gains." He further added that the "treatment plan," which designed for services to be provided as needed to address her symptoms, "has a goal of decreasing swelling and inflammation, decreasing spasms, increasing the ability to perform normal activities of daily living, increasing strength and increasing function."

115. According to the ASHN instructions, Dr. Clarke was to submit his information to ASH Networks, located in San Diego, CA 92150-9001, with an out-of-state fax number provided. Following those instructions, Dr. Clarke subsequently submitted his records on May 29, 2012.

116. ASHN submitted a Response Form to Dr. Clarke's submission the very next day, May 29, 2012, under the signature of Clinical Service Manager D. Gottschalk, M.D., in which it denied coverage for the office visit and the two therapies. Explaining the denial, ASHN stated:

> Your provider, Steven Clarke, DC, reported that you . . . are receiving Chiropractic care for neck pain, shoulder pain and mid back pain. Your clinical information and treatment/services from 05/04/1012 through 05/14/2012 were submitted to us for review.
>
> We performed a thorough review of your clinical information such as your history, current complaints, evaluation findings and diagnosis. Based upon your clinical information regarding the condition(s) for which you are seeking treatment, we did not grant approval for any of the treatment/services submitted under this treatment plan for the following reason(s):
>
> - Your clinical information shows that the condition(s) for which you are seeking treatment has reached the highest level of improvement and you have received maximum therapeutic benefit from the care you received. It is expected at this point you will no longer require covered treatment/services.
>
> - Your medical history shows you have received ongoing care but have not shown any lasting improvement. Continuation of the same or similar types of treatment is not likely to improve your condition. Treatment should change or stop.

117. Because the patient was obtaining relief from her symptoms (pain), she continued to see Dr. Clarke for his medically necessary services. ASHN, however, continued to deny coverage for the same reasons as reflected in its May 29, 2012 Response Form, dated ***the same day*** it received the request for coverage from Dr. Clarke.

118. ASHN's imposition of burdensome paperwork and precertification requirements on Dr. Clarke, as an OON provider, was not only improper and unnecessary, but also in violation of the underlying plan documents, which do not impose such requirements for purposes of obtaining health care services. Moreover, ASHN's denial of benefits reflects that fact that it does not undertake a case-by-case evaluation of the patient's medical condition and the medical

necessity of the proposed treatments, but, instead, imposes undisclosed policies designed to reduce benefits so as to save CIGNA money and enhance fees paid to ASHN.

119. In its health care plans, CIGNA incorporates a standard definition of "Medical Necessity" which governs what services are to be covered under the plan. As reported on the cigna.com website, the "CIGNA HealthCare Definition of Medical Necessity" is as follows:

> Except where state law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" shall mean health care services that a Healthcare Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
>
> - in accordance with the generally accepted standards of medical practice;
> - clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
> - not primarily for the convenience of the patient or Healthcare Provider, a Physician or any other Healthcare Provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

120. As reflected in Dr. Clarke's report of his patient's medical condition, she suffers ongoing pain and related symptoms which, while chronic, can nevertheless be treated to allow for improvement in those symptoms. When they reoccur, she can then obtain additional treatments to further reduce her pain, thereby treating the symptoms she is experiencing. Under generally accepted standards of medical necessity within the chiropractic community, and as defined within CIGNA's health care plans, Dr. Clarke's services are therefore medically necessary, particularly given that the definition does not require a "cure," but only an effective ability to "evaluat[e], diagnos[e] or treat[]" the "symptoms" of an illness, injury or disease.

121. ASHN's response, however, demonstrates that it ignores this definition, but applies its own internal policies which require any treatment to have "lasting improvement" which will "improve [the patient's] ***condition,***" meaning that ASHN takes the position that

treating the symptoms and alleviating pain will not be covered if that pain ultimately returns. According to ASHN's interpretation of medical necessity, that means that patients who suffer chronic pain cannot obtain covered treatments which alleviate that pain, but cannot resolve it permanently. Such a conclusion is arbitrary and capricious, and in violation of the clear terms and conditions of the CIGNA health care plans.

122. With regard to ASHN's denial of the two therapies proposed by Dr. Clarke, ASHN stated as follows:

> Your provider, Steven Clarke, DC, reported that you . . . are receiving Chiropractic care for neck pain, shoulder pain and mid back pain. The Transcutaneous Electrical Nerve Stimulation (TENS) therapy submitted for review by your provided was denied approval. The current clinical guidelines only supports the use of TENS for relieving pain associated with knee osteoarthritis. The evidence of a clinical benefit for the use of TENS for any other condition has not been established. Of the 2 therapies submitted for review, we approved payment for 0 therapies.

123. ASHN's conclusion that TENS was not a covered service has no valid basis and derives from guidelines which (1) are not part of the underlying plan documents; (2) are inconsistent with generally accepted medical standards; and (3) contradict CIGNA's own "Medical Coverage Policy." This example therefore demonstrates that ASHN makes medical necessary determinations based on its own unsupported and unsubstantiated policies designed to reduce coverage, in violation of ERISA.

124. Under CIGNA's own policy, it "covers [TENS] as medically necessary for EITHER of the following: chronic pain . . . when there is failure of at least a three-month trial of conventional medical management including medication (e.g., nonsteroidal anti-inflammatory drugs ([NSAIDS], acetaminophen) and physical therapy; [or] as an adjunct to conventional post-operative pain management within 30 days of surgery." CIGNA further only finds the use of TENS to be "experimental, investigation or unproven" when provided for the following

conditions: "acute and chronic headaches; abdominal pain; pelvic pain; [and] temporomandibular joint (TMJ) pain." Yet, ASHN denied the use of TENS for Dr. Clarke's patient without even inquiring as to what treatments the patient had previously tried to use to treat her chronic pain, and did so by limiting coverage to knee osteoarthritis when even CIGNA does not accept such a limitation.

125. Notably, ASHN has also gone well beyond making coverage determinations, but also is making improper medical judgments. In particular, rather than merely stating that the treatments are not "covered" under the health care plan because they do not fall within the definition of medical necessity as defined by ASHN, ASHN goes on to state to that continuing the treatment she was receiving from Dr. Clarke "is not likely to improve your condition" and that "treatment should change or stop." Thus, ASHN is making its own medical judgment of the treatment to be provided to the patient without providing proper medical evaluation of the patient's condition or the impact of the treatments provided by Dr. Clark.

126. The fact that ASHN, when provided Dr. Clarke's submission in California, issued its denial on the ***same day***, further demonstrates that ASHN's statement that it had conducted a "thorough review of all of [the patient's] clinical information" was false and misleading. Rather than making a determination based on the actual medical records of the patient, ASHN merely applied stock language used to deny benefits, without regard to the individual circumstances of the patient.

127. By letter dated May 30, 2012, ASHN informed Dr. Clarke's patient of its decision denying coverage for the services provided on May 4, 2012, repeating the statements contained in the Response Form provided to Dr. Clarke. This included the following: "Continuation of the

same or similar types of treatment is not likely to improve your condition. ***Treatment should change or stop***."

128. The patient who was treated by Dr. Clarke on May 4, 2012, was a regular patient for whom Dr. Clarke had submitted a number of prior claims to Defendants, all with identical denials. Following those denials, Dr. Clarke made repeated efforts to obtain additional information necessary to undertake an appeal or to otherwise challenge Defendants' adverse benefit determination, but without success. After one such denial, the patient herself sought to initiate an appeal process by requesting additional information from Dr. Greene, the Clinical Service Manager identified on the Response Form at issue (as compared to Dr. Gottchalk, who was the Clinical Service Manager for subsequent decisions). In particular, by letter dated December 23, 2011, the patient made the following request:

> I am respectfully requesting a copy of the written evaluation you used in the determination you made on my care with the computer generated treatment Form . . . with American Specialty Health Networks, Inc. My provider has attempted to reach you on a number of occasions and has been unable to either speak directly with you or get a return phone call with you so that he can discuss and review my care at his office. Reading through my ASHN Response Form dated December 09, 2011, it states that I may contact the Clinical Service Manager with "questions concerning any clinical modifications or denials," which I am respectfully requesting here. I am authorizing you to release my information [and] would appreciate receiving your complete written report/evaluation on my file so that I may understand why my care was reduced and how I can work to be covered for any/all benefits I am entitled to.

129. The patient never received a response to this inquiry. ASHN's uniform and standard practice of applying its undisclosed internal policies to deny and reduce coverage, without regard to the terms and conditions of the underlying plan documents, its failure to disclose that it was relying on policies which conflicted with CIGNA's own policies as well as with generally accepted medical standards, its misrepresentation that it had conducted individual assessments of the medical necessity of the treatments provided to the patient when instead it had

applied stock denials without evaluating the patient's actual condition or the medical necessity of the treatments she received, and its refusal to respond to a request for additional information necessary to provide a basis for continuing an internal appeal, and CIGNA's blanket delegation of its fiduciary duties to ASHN in making coverage decisions relating to chiropractic services all demonstrate that any further internal appeals would be futile and should therefore be excused. Further, Defendants' conduct, including the misrepresentations contained in its disclosures to Dr. Clarke and his patient, are in violation of ERISA and its underlying regulations, such that there should be "deemed exhaustion," thereby permitting this litigation to proceed.

ASHN's Reliance on Improperly Credentialed Personnel

130. In making coverage decisions, whether improperly as part of its pre-certification requirement or through a retroactive review, ASHN must use qualified personnel who have experience and training in providing coverage determinations. In New Jersey, for example, the law states:

> ***It shall be unlawful for any person, not duly licensed in this State to practice chiropractic***, to use terms, titles, words or letters which would designate or imply that he or she is qualified to practice chiropractic, or to hold himself or herself out as being able to practice chiropractic, or offer or attempt to practice chiropractic, or ***to render a utilization management decision that limits, restricts or curtails a course of chiropractic care.***

R.S.45:9-14.5(d) (2012) (emphasis added).

131. As detailed above, for example, ASHN indicated in Response Forms provided to Dr. Clarke for at least two of his patients that the Clinical Service Manager who made the decision denying coverage for certain services he provided was Dr. Greene, an M.D., not a D.C. Based on research conducted by Dr. Clarke, this appears to be a family practice physician who is ***not*** licensed to practice chiropractic medicine in New Jersey.

132. Similarly, after Dr. Clarke submitted another CFT, ASHN responded with a Response Form dated November 11, 2011, again rejecting a certain number of treatments and modalities which had been requested by Dr. Clarke for use with respect to a CIGNA Insured patient. This time, the identified Clinical Service Manager was "Dana Ann Ryan, M.D." Finally, yet another time, the Clinical Service Manager was identified as Dr. Gottschalk. Dr. Clarke's subsequent investigation failed to reveal any evidence that these individuals were licensed to practice chiropractic medicine in New Jersey.

133. The actions taken by Dr. Greene, Dr. Ryan and Dr. Gottschalk, on behalf of ASHN and CIGNA, constitute pre-service utilization management restrictions relating to a course of chiropractic care. As such, their actions fall squarely within R.S.45:9-14.5(d), thereby requiring that the decision be made only by a New Jersey-licensed chiropractor. Upon information and belief, none of these Medical Doctors satisfy this requirement, such that CIGNA and ASHN violated New Jersey law by allowing them to make the utilization review determination.

134. Following the receipt of the pre-authorization denials, Dr. Clarke sought confirmation from ASHN that it had used a proper licensed chiropractor to make its decision, but ASHN refused to provide that confirmation. Among other things, ASHN refused to allow Dr. Clarke to speak to the Clinical Service Manager, but merely asserted, without any validation, that they had "overseen" the process and that "a chiropractor was involved in the review." The failure to allow Dr. Clarke to speak to the person who made the denial decision also inhibited his ability to pursue an effective appeal of the benefit denials. No evidence or even assurance was provided that a chiropractor licensed in New Jersey, as required by law, had reviewed Dr. Clarke's CSFs and made the underlying utilization review decision.

135. After Defendants refused to correspond with Dr. Clarke concerning the qualifications or license of the individuals making utilization review decisions with regard to the chiropractic services he provided to his patients, he filed a series of complaints with the New Jersey regulators seeking to challenge ASHN's practices. On September 6, 2011, ASHN responded to Dr. Clarke's complaints – through outside counsel – in a letter to the New York Attorney General's Office. In that letter, ASHN took the position that R.S.45:9-14.5(d) "does not and, indeed, legally cannot apply to ASH's New Jersey operations." Notwithstanding the fact that the Act applies specifically to "utilization management decisions" involving chiropractic care, ASHN argued that "UM determinations are coverage decisions, not chiropractic care decisions." This ignores, however, that ASHN did not limit its decisions solely to coverage, but also issued findings as to the propriety of the care and even made recommendations to the patient that the care being provided by Dr. Clarke "should change or stop."

136. ASHN further argued that ERISA preempted the state law, to the extent it was deemed to apply to utilization management decisions. Here, however, ASHN ignores the fact that, under ERISA, a court has discretion to apply federal common law in holding that an action which is directly contrary to state law is in and of itself an arbitrary and capricious act in violation of ERISA. Moreover, the New Jersey law does not contradict or conflict with ERISA, such that it should not be deemed to be preempted in any event.

137. In its opposition letter, ASHN also included a statement from Dr. Green (identified as Justine Greene, MD, of San Diego, California), dated September 11, 2011. In her statement, Dr. Greene asserts as follows:

> As a function of my employment, I participate in utilization management decision-making processes by reviewing utilization reviews performed by chiropractors who are either on American Specialty Health Network's staff and licensed in New Jersey or who are consultants engaged by American Specialty

> Health Network, but who are nonetheless New Jersey-licensed chiropractors. When it was submitted, I reviewed the clinical treatment form . . . involving the above-named patient and provider and found the staff chiropractor's recommendations to be appropriate. A letter was then generated to the provider and patient documenting these recommendations.

138. Whether or not these statements are true as not been verified, but the fact that ASHN issued its Response Forms within a single day after the CFT was submitted by Dr. Clarke raises serious questions concerning whether these statements could be accurate. Moreover, while ASHN denied benefits requested by Dr. Clarke, it never offered or made available to Dr. Clarke or his patient the identity of the so-called "staff chiropractor," or his "recommendations," which served as the basis for the benefit denial. As a result, ASHN precludes any ability of Dr. Clarke or other providers or patients to challenge the validity of ASHN's benefit determinations, including whether they comply with New Jersey law.

139. After Defendants failed to respond to Dr. Clarke's inquiries over ASHN's claims review processes, in November 2011 Dr. Clarke also filed a complaint with regard to Dr. Ryan, who had been identified as another Clinical Service Manager responsible for another benefit denial. In an April 3, 2012 letter to the New Jersey Attorney General, ASHN (through outside counsel) reiterated its position that the New Jersey law did not apply to it and that it was preempted by ERISA in any event. In addition, ASHN repeated the position it had taken with regard to Dr. Greene, that Dr. Ryan had "provided oversight in connection with the UM decisions that ASH's New Jersey licensed chiropractor consultant or staff members had reviewed as part of ASH's medical necessity verification process." For the first time, ASHN also identified the purported "New Jersey licensed staff chiropractor" as being "W.R. Snyder, D.C. NCBTMB." At the same time, ASHN reasserted its view that New Jersey law does "not require a New Jersey licensed chiropractor for managed care UM determinations."

140. Plaintiffs again do not accept the validity of ASHN's assertions. Given the facts, which indicate that a benefit decision was made in California within a single day of the receipt of a claim from Dr. Clarke, it appears extremely unlikely that a New Jersey licensed chiropractor actually reviewed the underlying medical records and reached an determination as to the medical necessity of the services at issue, provided that recommendation to Dr. Ryan, who then evaluated and agreed with that finding and authorized sending the Response Form to Dr. Clarke. Moreover, the failure of ASHN to provide the identity of the chiropractor who purportedly made the decision to Dr. Clarke, or to provide the underlying report that was relied upon in making the utilization management decision, precludes Dr. Clarke or other similarly situated providers or patients from challenging the benefit denial.

141. Notably, Defendants have never issued any communications regarding the licensure of Dr. Gottschalk, the third Clinical Service Manager involved in making benefit denials with regard to Dr. Clarke, or whether or not he relied on a New Jersey licensed chiropractor in making his decisions.

142. Based on information and belief, CIGNA and ASHN have violated R.S.45:9-14.5(d), both by using providers who are not properly licensed in New Jersey to make the utilization review denials and by refusing to provide any back-up confirmation to Dr. Clarke.

143. This is clear from the legislative intent underlying R.S.45:9-14.5(d), as reflected in a August 16, 2012 letter from New Jersey State Senate President Stephen M. Sweeney to Kenneth E. Koblowski, Commission of the New Jersey Department of Banking and Insurance, in which Mr. Sweeney cites to R.S.45:9-14.5(d) and then states:

> As Prime Sponsor of this legislation, this particular wording was put in place for the following reasons:
>
> 1. To prohibit anyone not licensed in the State of New Jersey to impersonate a chiropractic physician or illegally practice chiropractic.

> 2. To require that a *Utilization Management* decision rendered by an insurance company and/or 3rd party be performed by a licensed New Jersey chiropractic physician compelling the chiropractor(s) performing utilization management to abide by New Jersey Statutes and Regulations that have been promulgated and are in place for the chiropractic profession.
>
> The legislative wording above was put in place to protect the public from unlicensed individuals and to provide the ability to know who the reviewer is and, if necessary, to be able to file a complaint to the New Jersey Board of Chiropractic Examiners, should the reviewer not be found to be complying with all statutes and regulations that are in place for the chiropractic profession.

144. Missouri has a comparable law to that of New Jersey. The Missouri law states that to deny in whole or in part services rendered by a chiropractor a consultant retained by the insurance company shall:

> Be licensed and practicing as a chiropractor in the state of Missouri, and, if the claim is made from a metropolitan statistical area in Missouri as that term is defined by the United States Bureau of the Census, then he shall be practicing as a chiropractor in any such metropolitan statistical area in Missouri; or be licensed and practicing as a chiropractor in the state in which the claim is reviewed; (2) Obtain a certificate from the board of chiropractic examiners, which shall indicate that the licensee has complied with the provisions of this section and has met the minimum standards contained in this section.

RSMo 376.423.1(1) and (2). ASHN also fails to follow this requirement.

145. In making pre-service benefit determinations, as well as evaluating services for medical necessity, Defendants are acting as fiduciaries under ERISA. As a result, they must make decisions in the interest of the beneficiaries and in compliance with the terms and conditions of the CIGNA Plans at issue. These Plans, either explicitly or implicitly, incorporate statutory requirements relating to health insurance coverage and utilization management procedures. As a result, Defendants must comply with applicable state statutes governing such practices when acting as an ERISA fiduciary, so long as there is no conflict between ERISA and the state laws. In this case, there is no conflict between ERISA and R.S.45:9-14.5(d) or RSMo 376.423.1(1) and (2). Defendants therefore have violated ERISA by making utilization

management decisions which restrict chiropractic services without complying with New Jersey law.

Impermissible Limits on Coverage for Chiropractic Services

146. CIGNA's Plans purported to provide coverage for medically necessary health care services provided by chiropractic physicians. Such Plans do not preclude chiropractors from providing services that fall within their license to practice, which means that the chiropractors can not only provide spinal manipulation, but also – depending on the state license – a broad range of other services as well. To the extent CIGNA's Plans do not preclude coverage for such other services, CIGNA therefore cannot deny coverage.

147. ASHN has publicly recognized the important health care benefits that can be provided by chiropractors. In testimony before the Department of Health and Human Services, for example, ASHN stated that "chiropractic is safe and clinically effective for the management of the health and illnesses of Americans," adding that "evidence-based chiropractic has been demonstrated to be cost-effective and a direct off-set substitution for higher cost services provided by other segments of the health care system." Moreover, ASHN has recognized that coverage for chiropractic services should not be limited solely to spinal manipulation, stating:

> We would recommend against a Medicare type benefit design. Medicare currently excludes coverage for services other than Chiropractic Manipulative Therapy including exclusion of physical examinations, radiographic/x-ray examination, and other physical medicine services. This type of limited benefit does not cover the necessary services provided by a chiropractor and results in cost shifting to the member for the non-covered services such as the physical examination and radiographic/x-ray examination.
>
> Since evidence-based health care demands that a chiropractor provide (i) all new patients with an examination and (ii) some new patients with radiographic examination, every patient will be required to pay for necessary but non-covered services.
>
> If chiropractic examinations, radiographic x-rays and physical medicine services were excluded similar to Medicare, this would cause significant patient

> dissatisfaction since virtually all current insurance plans cover all routine chiropractic services including physical examinations, radiographic/x-ray examinations, chiropractic manipulative treatment and other physical medicine services.

148. Notwithstanding that CIGNA's Plans permit coverage for a variety of services provided by chiropractic physicians, and ASHN's own representations concerning why coverage should extend beyond manipulation services alone, ASHN has adopted policies which obstruct the delivery of medically necessary services provided by chiropractors. For example, ASHN not only limits coverage for chiropractic services to patients with Neuromusculoskeletal Disorders, but also limits other types of covered services in states where chiropractors are licensed to provide them. While such services are covered under the CIGNA Plans, ASHN refuses to provide benefit payments when chiropractors provide such services.

149. Moreover, CIGNA's Plans cover preventive care, as required under most state laws and PPACA. Thus, its standard Plans state: "Your plan covers the preventive services listed here 100 percent as part of preventive care" if the Insured receives such care "from a doctor or other health care provider in our network." This is confirmed in a CIGNA booklet it distributed to CIGNA Insureds which states:

> **Preventive care covered 100 percent.** Good news! Your plan covers the preventive services listed here 100 percent as part of preventive care. This includes routine screenings and checkups. It also includes counseling to prevent illness, disease or other health problems. You won't have to pay anything for these services when you get them from a doctor or other health care provider in our network... That means no copayment and no coinsurance. You don't have to meet your deductible first.

150. In many states, including Connecticut, chiropractors can provide preventive services such as screening for cholesterol and blood pressure, and services relating to obesity, tobacco cessation and osteoporosis, among others. Notwithstanding that such services are covered under the CIGNA Plan and fall within the licenses of chiropractors, Defendants –

through ASHN's policies – fail to cover such benefits, even after an order by the Connecticut Attorney General. Specifically, ASHN's policy, CPG 12 Rev. 12 "Clinical Service(s) Denial (Adverse Determinations)" states that Preventive Care is one type of care that they will not cover, reflecting a clear contraction with both CIGNA Plan documents and various laws governing health insurance policies.

151. Defendants also preclude coverage for services that should be covered under the Plan by imposing policies that only allow a chiropractic physician to be paid for providing one therapy service per day. Thus, while the CIGNA Plans typically permit chiropractic services, including therapy, without limiting how many services are offered each day, ASHN makes that benefit illusory by only paying for a one or two ***treatments*** per day, even though the chiropractic physician may find other services to be medically necessary and be licensed to provide them, including such modalities as manual therapy, mechanical traction, and other physical therapy services.

152. By imposing these unreasonable limits on coverage for all but a one or two therapy treatments per day, ASHN is forcing either the provider to offer medically necessary services without reimbursement, the patient to pay for medically necessary services out-of-pocket, or to bring the patient in for additional visits, which then reduces the number of available visits remaining under the patient's Plan.

153. Notably, CIGNA allows the limitation of one or two modalities per visit to chiropractic patients due to ASHN policies, but does not permit the same limitation of the physical therapy benefit even though the same codes to describe the treatment are used. Given that ASHN's rationale for their policy is that more than one or two modalities is considered "redundant," there is no rational basis for this conclusion to apply to chiropractors, but not

physical therapists, when the same type of services are provided. Defendants are clearly allowing dual standard to be applied to plan beneficiaries' care without disclosing such limits in CIGNA's policies.

154. Similarly, Defendants restrict coverage for diagnostic imaging when provided through a chiropractic physician in a manner not solely based upon medical necessity. While X-rays, MRIs and CT Scans are covered services under CIGNA Plans, and chiropractic physicians in many states are qualified and licensed to order such services, when needed, ASHN again limits such services. ASHN's Policy, CPG 12 Revision 12 (Revised Nov. 17, 2011) "Medical Necessity Decision Assist Guideline for Musculoskeletal Conditions and Somatic / Neuropathic Pain Disorders," states that "ASHA does not typically cover special studies (e.g., CT, MRI, NCV) and lab services…" By stating that it does "not cover" these sometimes medically necessary, covered tests, ASHN is super-imposing its own policies over what the Plan allows and is withholding necessary care by stating it "**does not cover"** these tests. As a third-party administrator, this far exceeds its role. The fact that CIGNA allows this restriction demonstrates a failure to fulfill its fiduciary responsibilities and is a violation of ERISA.

155. This same limitation extends to x-rays. If a patient is examined by licensed DC, and CIGNA policy would cover the service, the patient should not be required to go through the burden of cost and time to see additional providers. As described above, depending on Tier designation, physicians may be required to have x-rays preauthorized. As x-rays are sometimes determined to be needed during the initial exam, the physician obtaining the x-ray within this narrow window of time early in the patient's care has no way of knowing whether the x-ray will be covered and, in fact, commonly, such x-rays are denied simply based upon ASHN's policies. In one case, a patient who had x-rays denied at a provider's office after going through the

preauthorization process had the same x-rays taken at the office of a medical doctor where they were covered without question by CIGNA.

156. Dr. Clarke's experiences with regard to the TENS procedures further demonstrates this allegation. As described above, CIGNA policy allows for TENS as a means to treat chronic pain, but ASHN nevertheless improperly denies coverage based on the application of its contradictory policy that such treatments are limited solely to knee osteoarthritis.

Illusory Benefits Resulting From Excessive Copayment Requirements

157. While CIGNA's Plans purport to provide coverage for chiropractic services, Defendants are imposing copayments on patients that can exceed the amount considered "allowable" payment under a provider contract. For example, certain CIGNA Plans in Connecticut require CIGNA Insureds to pay a copay of $60 for chiropractic visits. Yet, under the ASHN contract imposed on chiropractors, the maximum allowable payment to a chiropractor on any given date of service is $44. As a result, CIGNA will ***never*** pay any benefits toward chiropractic services, and thus bears no risk, since the copayment obligation of the patient will always exceed the amount owed to the provider.

158. Any time Defendants' policies create a scenario in which the copayment owed by the CIGNA Insured is equal to or greater than the amount it will cost Defendants, due to their limits on coverage for chiropractic services, the chiropractic benefit offered by Defendants is illusory and is in violation of ERISA.

Reliance on Flawed and Inaccurate Medical Necessity Policies

159. In making coverage decisions, both as part of its pre-authorization process and retroactively, Defendants rely on various internal policies designed to allow for an evaluation of submitted claims to determine whether the identified services are covered under the CIGNA

Plans as "medically necessary." These policies, however, are flawed and inadequate, in violation of generally accepted standards within the chiropractic profession.

160. In applying its pre-authorization requirements on doctors of chiropractic, ASHN applies a uniform definition of "medical necessity" which purportedly is consistent with the definitions contained within its CIGNA health care plans. This definition, as reflected in its policy UM 8 Rev. 7-S "Medical Necessity Definition" (updated 5/17/12) and in a Medical Necessity announcement issued January 20, 2012, provides that it will cover services which are "in accordance with Generally Accepted Standards of Medical Practice"; "clinically appropriate" and "considered effective" for the patient's condition; and "not primarily for the convenience of the patient or healthcare provider" or "more costly" than equally effective "alternative service[s]." As applied by ASHN, however, it fails to comply with "Generally Accepted Standards of Medical Practice" because it imposes requirements, and limits coverage, through internal guidelines which are not generally accepted by the chiropractic profession.

161. In establishing its internal guidelines for coverage of chiropractic services, ASHN purports to recognize and follow the recommendations of the Council on Chiropractic Guidelines and Practice Parameters ("CCGPP"), which was formed in 1995 by the Congress of Chiropractic State Associations ("COCSA"), with the assistance of the American Chiropractic Association, Association of Chiropractic Colleges, Council on Chiropractic Education, Federation of Chiropractic Licensing Boards, Foundation for the Advancement of Chiropractic Sciences, Foundation for Chiropractic Education and Research, International Chiropractors Association, National Association of Chiropractic Attorneys and the National Institute for Chiropractic Research. The CCGPP's mission was "to provide consistent and widely adopted chiropractic practice information, [and] to perpetually distribute and update this data, as is necessary, so that

consumers and others have reliable information on which to base informed health care decisions."

162. Through the CCGPP, an evidence-based series of best practices have been established which allow for a proper evaluation of medically necessary chiropractic treatments, as reflected in various peer-reviewed publications, including "What Constitutes Evidence of Best Practice?," by John J. Triano, D.C., PhD, published in Volume 31, Issue 9, Pages 637-43, of the Journal of Manipulative and Physiological Therapeutics. Under the medical necessity definition incorporated into the applicable health care plans, and the in-network provider agreements governing chiropractors subjected to ASHN policies, ASHN should be complying with the CCGPP policies, as reflective of generally accepted chiropractic standards, but it is not.

163. In an April 13, 2012 release entitled "Medical Necessity – Part 3; Evidence-based Approach for Medical Necessity Verification," ASHN cites the CCGPP and states that "[i]t is the recommendations of these guidelines relative to the duration and frequency of services (dose) that serve as the comparison" for services provided by ASHN chiropractors. Thus, ASHN highlights the following statement of the CCGPP:

> Recommended therapeutic trial ranges are representative of typical care parameters. A typical initial therapeutic trial of chiropractic care consists of 6 to 12 visits over a 2- to 4-week period with the doctor monitoring the patient's progress with each visit to ensure that acceptable clinical gains are realized.

This conflicts with the information from ASHN (provided above) which states that what they found was that over fifty percent of patients' conditions resolved in five visits or less.

164. The frequency and duration for an initial trial of chiropractic treatments is then provided, with acute or subacute conditions showing three times weekly for 2-4 weeks, after which a reevaluation by the treating provider is proper; chronic conditions showing two to three

times per week for 2-4 weeks, and recurrent/flare-up conditions showing one to two times per week for one to two weeks.

165. After an initial course of treatment, leading to a follow-up review, the CCGPP further states that "a reasonable therapeutic trial for managing patients requiring ongoing care is up to 4 visits after a therapeutic withdrawal." If the re-evaluation suggests further care is required, it "may be delivered at up to 4 visits per month," with "[a]n appropriate re-evaluation [to] be completed at minimum every 12 visits."

166. Significantly, the CCGPP guidelines are intended to provide suggested conduct for the ***treating provider*** to ensure that a proper level of care is provided to the patients, with necessary re-evaluations on an on-going basis. ASHN, however, distorts these findings to give it carte blanche to substitute its own guidelines on the level of care provided by the treating chiropractors. The CCGPP guidelines were developed through an internationally accepted literature review protocol and have been widely accepted by the chiropractic profession and its colleges. ASHN's process of developing their guidelines is largely unknown other than their publishing of their lists of committees and review processes.

167. Based upon its guidelines, ASHN imposes a requirement that it provide pre-approval of any sessions after the first five, regardless of whether such pre-authorization is permitted under the patient's plan. In comparison, the CCGPP suggests an initial trial of up to ***12*** sessions, before a re-evaluation is performed *by the treating provider.*

168. ASHN's Medical Necessity policy further describes the CCGPP recommendations as follows:

> The "typical" range for services for therapeutic trials of care . . . is 1 to 12 visits for acute care and 1 to 6 visits for recurrent exacerbations in a chronic patient. There is an understanding that some patients will require a greater number of

> services based on such factors as stage of care, severity, and individual health factors that promote or inhibit a favorable response.

169. This summary, which ASHN uses to justify its own policies, is blatantly inaccurate while omitting CCGPP's second table describing "Frequency and duration for continuing course of treatments," allowing a second round of 12 visits. Moreover, the CCGPP recommendations do ***not*** state that the initial round of up to 12 visits is limited to "acute care," as ASHN asserts. In addition, the CCGPP reference to 1-6 visits as purportedly related to episodic care is taken out of context and omits an entire class of patients who require ongoing scheduled care due to the severity of their conditions and failed attempts at therapeutic withdrawals. ASHN is therefore cherry-picking selected CCGPP statements and misinterpreting them to support ASHN's restrictive policies.

170. The CCGPP guidelines also are clearly designed to permit ongoing care when needed to treat a patient's condition (such as pain that otherwise cannot be eliminated), with proper re-evaluation by the provider as care is offered. In contrast, ASHN follows what is, in effect, a hidden cap on treatments by limiting care based on their skewed model, and then denying coverage as excluded under the health care plans as "maintenance care." "Maintenance care" is uniformly defined by ASHN in administering its plans as "care given that is designed to reduce the incidence or prevalence of illness, impairment, and risk factors, and to promote optimal function, not for a specific health condition," as reflected in ASHA Policy CPG 12 Rev. 12 (Revised Nov. 17,2011). This means that when a patient is treated for a condition (*i.e.*, *cervical retrolisthesis*), and the treatment provides relief for the condition, even without a permanent cure, that is ***not*** maintenance care.

171. Yet, ASHN improperly applies the maintenance care exclusion to chronic patients who, in their view, are not making sufficient progress, within their prescribed limited number of

treatments. . As such, it abuses its policy in its Practice Parameters and Review Criteria (CPG 1 Rev. 8, dated Apr. 24, 2003) which states: "It is appropriate not to approve ongoing services if the member's condition is no longer improving despite the services being rendered by the treating practitioner." ASHN does not apply proper utilization review to assess the progress of chronic patients and as a result neglects and abandons the care of this vulnerable population of over 145 million Americans over fifty percent of whom have multiple conditions making their management complex. These patients may require adjustments to their treatment plans to assess what treatment results in the best outcomes and coordination with other providers. Such management often requires longer care episodes. However ASHN, not only cuts off care according to their policy, they do so in conflict with their published materials which detail the cost-effectiveness of chiropractic care. Forcing chronic patients who choose chiropractic treatment to manage their conditions to more costly types of treatment such as surgery, pharmaceuticals, and other specialists shows that ASHN's policies are not in keeping with current efforts to reduce healthcare costs, with patient-centered healthcare to support patient choice, and that their motives are focused on profits rather than evidence-informed patient care.

172. In 2009, the CCGPP, in a Delphi Multi-Disciplinary Consensus Panel Project, developed a set of definitions for the stages of care due to inconsistent use of terms by different payers, regulators and providers. The definitions were developed through a rigorous scientific process and studied terms including acute, chronic, maintenance, and recurrent care. They concluded that the term "maintenance" **was no longer supported by the literature**. The following is an excerpt regarding continued care for chronic conditions:

> ***Management of Chronic/Recurrent Conditions*** - Medically necessary care of recurrent/chronic conditions is care that is provided when the injury/illness is not expected to completely resolve following a treatment regimen, but where

> continued care can reasonably be expected to result in documentable improvement for the patient.
>
> When functional status has remained stable under care and further improvement is not expected or withdrawal of care results in documentable deterioration, additional care may be necessary for the goals of: supporting the patient's highest achievable level of function, minimizing or controlling pain, stabilizing injured or weakened areas, improving ADLs, reducing reliance on medications, minimizing exacerbation frequency or duration, minimizing further disability or keeping the patient employed and/or active.

173. In 2009, as shown in this work, additional care ***may be necessary*** when functional status has remained stable and further improvement is not expected, in order to control pain, to stabilize injured or weakened areas, to improve ADLs, to reduce reliance on medications, to minimize exacerbation frequency or duration, to minimize further disability or to keep the patient employed and/or active. These patient-centered goals are thwarted through ASHN's policy of labeling such patients as needing excluded "maintenance" care.

174. Despite ASHN's conclusion that coverage may be denied in such circumstances, the fact that the condition "is no longer improving" is irrelevant to the question of whether the chiropractic treatment offered by the provider is an effective means to treat the ***symptoms*** of such condition, a conclusion ignored by ASHN. As a result, ASHN's maintenance care policies are improper under the terms of the applicable health care plans and disallow needed and covered care.

175. ASHN asserts in its guidelines that its "clinical verification of medical necessity outcomes is consistent with the chiropractic professional treatment protocols as published" by the CCGPP, but such a conclusion is misleading. For example, it states that the CCGPP Guidelines show 6-12 sessions ***in total***. Even assuming that ASHN's reported numbers are valid, CCGPP does not state that the ***total*** sessions should be 12, only that "[a] typical therapeutic ***trial*** . . . over a 2- to 4-week period" should include 6 to 12 visits. ASHN turns this goal for the initial

"trial" as the ending goal for all treatment and, in so doing, ASHN's guidelines ignore the clear clinical support for more sessions as needed based on monitoring of the patients by the treating provider.

176. ASHN's data with regard to the average number of treatments its providers request is also artificially low, because it is based on figures derived from ASHN's in-network providers who are pressured – through the tiering program and the imposition of burdensome paperwork and built-in delays – to reduce the number of sessions they provide. It is further not representative of standard chiropractic practice due to providers who are unwilling to join the network due to ASHN's reputation or due to providers who have withdrawn from ASHN's network due to their restrictive and punitive practices.

177. In practice, ASHN frequently applies its policies to restrict or deny chiropractic services which are deemed to be medically necessary by the treating provider, and which otherwise comply with the standards of care articulated by the CCGPP and which are covered under CIGNA Plans. Under ERISA, Defendants should be enjoined from applying such policies and required to make medical necessity determinations consistent with generally accepted standards of care.

178. As a further means to manipulate its review of services to reduce benefits, Defendants effectively cherry pick the evidence that supports benefit denials, while ignoring conflicting evidence. For example, ASHN has denied approval of coverage for exercise therapy in the acute phase based on a policy that exercise therapy may be injurious to the patient and should not begin until four weeks following the onset of symptoms. This policy is flawed and contrary to acceptable standards within the chiropractic community.

179. In support of its policy, ASHN relies on a report by Dr. Craig Liebenson and the Philadelphia Panel regarding the use of exercise therapy for addressing low back pain. Yet, both of these texts contradict ASHN's policy that any type of exercise therapy in the acute phase is medically unnecessary.

180. In the 2nd Edition of *Rehabilitation of the Spine: A Practitioner's Manual* (2007), Dr. Liebenson states: "It is striking that early active care methods have been put in such a negative light when such weak evidence of their ineffectiveness exists. On the contrary, when new evidence is considered and all of the literature is evaluated from a fresh perspective, the value of properly recommended exercises from the very beginning of care becomes overwhelmingly clear."

181. The Philadelphia Panel Evidence Based Practice Guidelines on Selected Rehabilitation Interventions for Low Back Pain (2001) further explains that exercise therapy may well be effective in the treatment of acute low back pain, stating: "Our systematic review also showed that extension, flexion or strengthening exercises are effective for subacute and chronic LBP and for postsurgery LBP. The results for acute LBP are in full agreement with guidelines and other reviews concerning moderate effectiveness of stretching or strengthening exercises, but highly effective 'advice to stay active.'" While the Philadelphia Panel investigated single interventions as part of its analysis, other reviews studying the use of both manipulation and exercise therapy revealed a synergistic effect, leading to improved results greater than either of the interventions alone. ASHN does not know when it preauthorizes care which exercises will be prescribed and whether they will be passive or active. By having a blanket policy against all exercises within the acute phase, they contradict the policy of virtually every U.S. hospital which

require that post-surgical patients get up and walk or begin some type of exercise within a day of surgery, if possible.

182. As described above, CIGNA further frequently limits therapies based on its representation that "[r]esearch does not support the use of redundant therapies." This conclusion lacks support and is based on an improper and unsupported assumption that the therapies are "redundant." If such a statement were accurate, CIGNA would have a similar policy in place limiting physical therapists' treatment by the same protocols, which it does not.

183. Generally accepted standards in the chiropractic community are contrary to ASHN's policies with regard to the use of exercise treatment as part of a regimen for treating low back pain. Thus, any claims which have been determined by Defendants, in whole or in part, as a result of such policies should be reversed as arbitrary and capricious under ERISA.

184. The inadequacies in the policies applied by Defendants in making medical necessity decisions are further exacerbated by the fact that Defendants allow employees who are not licensed chiropractors in a particular state to deny or reduce chiropractic benefits in such state, in violation of various state scope of practice laws.

DEFENDANTS' VIOLATIONS OF STATE LAWS

Discrimination Against Chiropractic Physicians In Violation of State Anti-Discrimination Laws

185. A number of states, including Tennessee, have anti-discrimination laws that prevent a health insurer such as CIGNA from discriminating against chiropractors by applying policies and limits on chiropractic care that exceed those imposed on medical doctors. For example, Tennessee Law, Tenn. Code Ann. 56-7-2404 states:

> (a)(1) Whenever any policy of insurance issued in this state provides for reimbursement for any service that is within the lawful scope of practice of a duly licensed chiropractor, the insured or other person entitled to benefits under the policy shall be entitled to reimbursement for the services, whether the services are

> performed by a duly licensed medical physician or by a duly licensed chiropractor, notwithstanding any provision contained in the policy.
>
> (2) Whenever any insurance subscribers under any sickness and accident, medical service plan, hospital service contract or hospital and medical service contract, as provided under chapters 26-29 of this title or similar statutes, or any other persons covered by the plan or contract, are entitled to reimbursement for any services that are within the lawful scope of practice of a duly licensed chiropractor, the subscriber or other person shall be licensed medical physician or a duly licensed chiropractor, notwithstanding any provision to the contrary in any other statute or in the plan or contract; and duly licensed chiropractors shall be entitled to participate in the plans or contracts providing for the services to the same extent and subject to the same limitations as duly licensed medical physicians.

186. Similarly, Connecticut Code, Section 38a-534 ("Mandatory Coverage for Chiropractic Services") mandates that "[e]very group health insurance policy . . . shall provide coverage for services rendered by a chiropractor licensed under chapter 372 to the same extent coverage is provided for services rendered by a physician, if such chiropractic services (1) treat a condition covered under such policy and (2) are within those services a chiropractor is licensed to perform."

187. Defendants have violated these provisions by limiting coverage for chiropractic services which do not include the full scope of practice of chiropractic physicians.

188. Similarly, Defendants limit coverage for supports and appliances (such as braces) when provided by a chiropractor to only $50 per year, while allowing substantially more for medical doctors. As a result, CIGNA Insureds are penalized for choosing a chiropractor instead of a medical doctor in violation of the anti-discrimination laws.

189. Defendants' x-ray policies are also a prime example of their discrimination against chiropractors. ASHN imposes severe restrictions on a chiropractor's use of x-rays, despite this service falling within the chiropractor's license to practice, that are far more stringent than those applied to other health care providers. This limits the freedom of choice of CIGNA Insureds to obtain care through a chiropractor and violates their Plan terms in violation of ERISA and the state anti-discrimination laws.

Payments that Violate State Prompt Payment Provisions

190. Various state laws, including Tenn. Code Ann. § 56-7-109 and Missouri's RSMo 376.383 et seq., require insurers such as CIGNA to pay benefits within a specified period of time after the relevant claim has been received, with interest required when such payments are not made on a timely basis. Under the Tennessee code, for example, Defendants are supposed to pay claims within 30 days after receiving a paper claim, or within 21 days after electronic submission, with interest to be paid if these deadlines are not satisfied. Under the Missouri statute, for example, Defendants are suppose to pay claims within 30 processing days but no later than 45th processing day at which point penalties can accrue. Defendants, however, consistently ignore these laws and make payments to chiropractors with substantial delays, without paying any interest.

191. Often, delayed payments occur after CIGNA processes a claim and submits the payment to ASHN. By doing so, CIGNA is able to verify to regulators that it is in compliance with applicable regulations, since ASHN presents itself in various documents, including EOBs, as the provider. ASHN, however, then holds on to the payments for lengthy periods of time, such that it earns interest on those funds and prevents the chiropractors who actually provide the service from receiving timely payments.

192. For example, as of September 2011, one chiropractor practicing in the State of Ohio had over 600 claims from July and August that had been submitted for services provided to CIGNA Insureds which had not been paid. ASHN listed those claims on its website as "processed," stating that it was "awaiting response from the Health Plan." In fact, however, a large number of those claims had already been processed and paid directly to ASHN by CIGNA, with ASHN having already cashed the checks, but without releasing the funds to the provider.

193. When called by the provider, CIGNA reported the date the check was cashed and the service date, but other information was restricted because, in CIGNA's files, ASHN was improperly designated as the "provider." In further discussions, ASHN confirmed that it had no system in place to track when a claim had been submitted for more than 30 days, such that payment should be made to the provider. ASHN then stated that it was the provider's responsibility to track each claim individually and contact ASHN directly when a claim exceeded the 30 day requirement.

194. Defendants' failure to pay providers in a timely fashion for clean claims violates the applicable state prompt pay statutes. Defendants should therefore be enjoined from continuing its practices which lead to systemic delays in payment, and should be ordered to pay interest on delayed payments, both for prior delayed payments and future ones.

Violation of Utilization Management Statues

195. As detailed above, New Jersey law (R.S.45:9-14.5(d)) requires that any utilization management decision which restricts access to chiropractic services must be made by a New Jersey licensed chiropractor. Similarly, Missouri law (RSMo 376.423.1(2) requires a consultant to obtain a certificate from the board of chiropractic examiners. Defendants violate these

provision by allowing physicians who do not satisfy this requirement to make utilization management decisions.

CLASS DEFINITIONS

196. Plaintiff Lietz brings this action on her own behalf and on behalf of a "Subscriber Class," defined as:

> All CIGNA Insureds who, from six years prior to the filing date of this action to its final termination ("Class Period"), received benefit determinations from Defendants in which the allowed amount applied to the CIGNA Insureds' claim exceeded the allowed amount Defendants applied for purposes of determining the reimbursement level for the providers.

197. Dr. Clarke brings this action on his own behalf and on behalf of a "Provider Class," defined as:

> All healthcare providers who, from six years prior to the filing date of this action to its final termination ("Class Period"), provided healthcare services to patients insured under ERISA healthcare plans insured or administered by Defendants, and who submitted claims which were subject to the ASHN policies or practices defined herein, as part of the claims review or benefit determination process.

198. Claims under the state laws identified herein are not being asserted on behalf of Dr. Clarke or the Provider Class, but rather, by ACA in a representational capacity on behalf of its members, seeking appropriate equitable and injunctive relief. Thus, the state law claims are not being asserted on behalf of a class.

199. Plaintiffs bring claims against Defendants on their own behalf and on behalf of the putative Classes (1) to enjoin Defendants from engaging in the improper conduct allegedly here or otherwise relying on the internal policies which are challenged in this action; and (2) to reverse the adverse benefit determinations which were made as a result of Defendants' reliance on such policies.

COMMON CLASS CLAIMS, ISSUES AND DEFENSES FOR THE CLASS

200. The following common class claims, issues and defenses for Dr. Clarke and Ms. Lietz, and the Classes they represent, arise for the defined Class Periods:

1. Whether Defendants violate ERISA and interfere with the doctor-patient relationship by issuing EOB's which misstate the provider's billed and allowed amounts and increase the reported amount that is the financial responsibility of the patient;
2. Whether ASHN's policies requiring chiropractors to submit certain claims to ASHN for review in advance of providing such services ("pre-authorization policy") constitute "pre-service claims" under ERISA;
3. Whether Defendants have violated ERISA by imposing ASHN's pre-authorization policy without complying with ERISA's requirements for adverse benefit determinations;
4. Whether Defendants' policies limiting coverage for chiropractic services are in violation of ERISA, when such limitations are not detailed in its health care Plans;
5. Whether Defendants' imposition of copayment requirements on CIGNA Insureds which exceed the total amount CIGNA pays to chiropractors for daily services results in illusory benefits in violation of ERISA;
6. Whether Defendants' failure to pay benefits to Plaintiffs within the time parameters specified under ERISA regulations are in violation of ERISA;
7. Whether Defendants' policies for determining whether chiropractic services are medically necessary are contrary to generally accepted chiropractic standards, such that adverse benefit determinations based on such policies are inherently arbitrary and capricious;
8. Whether providers have standing to pursue claims under ERISA based on assignments that authorize insurers to pay such providers directly for covered services;
9. Whether CIGNA's actions with regard to Class Members results in a waiver of any objection to the validity of any assignments that may have been given by CIGNA subscribers, or whether CIGNA is otherwise estopped from asserting such an objection;
10. What the applicable statute of limitations periods are for the claims of Class members; and
11. What are the appropriate equitable remedies under ERISA for the alleged violations.

ADDITIONAL CLASS ACTION ALLEGATIONS

201. The members of the Classes are so numerous that joinder of all members is impracticable. Upon information and belief, the Classes consist of thousands of subscribers and chiropractic physicians who are subject to Defendants' policies which are the subject of this action. The precise number of members in the Classes is within CIGNA's 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.

202. The proposed Class Representatives' 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 Dr. Clarke and Ms. Lietz and the Classes through and by uniform patterns or practices as described above.

203. Dr. Clarke and Ms. Lietz will fairly and adequately protect the interests of the members of the Classes, 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 and other health care claims and have no interests antagonistic to or in conflict with those of the Class. For these reasons, Dr. Clarke and Ms. Lietz are adequate class representatives.

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

205. 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 Classes is impracticable.

Further, the expense and burden of individual litigation make it impossible for the Class members individually to redress the harm done to them. 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 ERISA
(On behalf of Plaintiffs and the Proposed Classes)

206. 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).

207. In making benefit determinations, and processing claims, Defendants must comply with the terms and conditions of the ERISA Plans. Utilization review requirements, including pre-authorization, are impermissible if they are not authorized under the ERISA Plans. Similarly, denial or reductions in benefits which are based on policies which do not comply with the ERISA Plans are arbitrary and capricious or otherwise invalid under ERISA.

208. Under ERISA, Defendants are required to issue EOBs to CIGNA Insureds with respect to benefit determinations which accurately report the amount billed by a treating provider and the amount deemed by Defendants to be the "allowed amount" under the applicable CIGNA Plan. Similarly, the amount allocated to the CIGNA Insureds' deductible or copayment should be no more than the allowed amount reflecting the amount paid to the provider.

209. Under the terms of the CIGNA Plans, the "allowed amount" which Defendants establish as the basis upon which it sets its reimbursement levels is a set number for each service received by a CIGNA Insured. It cannot vary depending on whether Defendants are informing the provider or the CIGNA Insured of the allowed amount.

210. Defendants violated their legal obligations under ERISA and federal common law each time they issued EOBs which reported a billed amount that was different from the amount

actually billed by the provider, and where the allowed amount was different from the allowed amount reported to the provider.

211. Because Defendants violated ERISA by issuing false and misleading EOBs, any obligation to exhaust administrative remedies have been waived, and the claims should be deemed exhausted. Moreover, given that numerous inquires and appeals have been filed relating to these practices without affect, any such appeals should be deemed to be futile.

212. Defendants violated their legal obligations under ERISA and federal common law each time they denied benefits or imposed utilization review requirements as detailed herein without complying with ERISA's requirements for dealing with adverse benefit determinations.

213. By pursuing the policies identified in the Complaint, without providing adequate disclosure or ensuring compliance with plan terms, Defendants failed to provide a "full and fair review" of adverse benefit determinations, failed to provide reasonable claims procedures, and failed to make necessary disclosures to its Insureds.

214. Appeals by Plaintiffs and members of the proposed Classes should be deemed exhausted or excused by virtue, *inter alia*, of Defendants' numerous procedural and substantive violations. Moreover, the failed appeals of many Class Members show the futility of exhausting appeals to Defendants. Exhaustion of internal appeals under ERISA should, therefore, be deemed to be futile.

215. During the Class Period, Plaintiffs and the members of the proposed Classes have been harmed by Defendants' 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.

216. Dr. Clarke and Ms. Lietz, on their own behalf and on behalf of the members of their respective Classes, seek to enjoin Defendants from pursuing the policies which are in violation of ERISA, as detailed herein, request that Defendants recalculate and reimburse benefits which were denied or reduced as a result of such policies, and pay appropriate interest back to the date such claims were originally submitted to Defendants. Plaintiffs, including ACA, also sue for declaratory and injunctive relief related to enforcement of Plan terms, and to clarify their rights to future benefits. Plaintiffs further requests attorneys' fees, costs, prejudgment interest and other appropriate relief against Defendants.

COUNT II

CLAIM FOR APPROPRIATE EQUITABLE RELIEF UNDER ERISA
(On behalf of Plaintiffs and the Proposed Classes)

217. The allegations contained in this Complaint are realleged and incorporated by reference as if fully set forth therein. Count II is brought under 29 U.S.C. § 1132(a)(3).

218. Under ERISA, Defendants must comply with the terms and conditions of the applicable Plans when processing claims and making benefit determinations. Further, Defendants are fiduciary under ERISA with respect to how they process claims and determine benefits under ERISA Plans. As part of these obligations, Defendants must issue valid EOBs and other reports which properly characterize the billed and allowed charges, who the provider is, and the proper amount owed by the subscriber as part of the benefit determination process. Under Section 502(a)(3) of ERISA, § 502(a)(3), Plaintiffs are entitled to sue for "appropriate equitable relief" arising from Defendants' violations of ERISA when engaged in administering ERISA Plans.

219. As detailed herein, Defendants have violated the Plans which cover the CIGNA Insureds as a result of their falsification of EOBs and other reports and the various ASHN policies which are designed to discourage the provision of chiropractic care. Similarly,

Defendants have breached their fiduciary obligations under ERISA as a result of the conducted identified here. Thus, Plaintiffs are entitled to appropriate equitable relief to address these violations under ERISA, including, but not limited to, removing Defendants as fiduciaries under the ERISA plans they currently administer.

COUNT III

VIOLATION OF APPLICABLE STATE LAWS
(on behalf of the ACA)

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

221. Defendants' practices violate the anti-discrimination statutes of various states, including Tenn. Code Ann. 56-7-2404, Connecticut Code § 38a-534 and Missouri RSMo376.1230 by limiting benefits and imposing burdens upon patients and physicians for chiropractic services below those for other providers. Similarly, Defendants violate the applicable state prompt payment laws, including Tenn. Code Ann. § 56-7-109 and Missouri RSMo 376.383 et seq. and violate applicable utilization management statues, including R.S.45:9-14.5(d) and Missouri RSMo 376.423.1 et seq.

222. The ACA, in a representational capacity on behalf of its members, seek appropriate declaratory and injunctive relief to enjoin Defendants from engaging in the conduct identified herein which is in violation of applicable state laws.

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

A. Certifying the Classes, as set forth in this Complaint, and appointing Plaintiff Lietz as Class Representative for the Subscriber Class and Dr. Clarke as Class Representative for the Provider Class.

B. Declaring that Defendants have breached the terms of their EOCs and SPDs and awarding unpaid benefits to Ms. Lietz and Dr. Clarke and the members of the Classes, as well as awarding injunctive and declaratory relief to prevent Defendants' continuing actions detailed herein that are undisclosed and unauthorized by EOCs and SPDs;

C. Declaring that Defendants failed to provide a "full and fair review" to Plaintiffs and the 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 Defendants violated their disclosure and related obligations under ERISA and federal common law, for which all Plaintiffs and Class members are entitled to injunctive, declaratory and other equitable relief;

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

F. Declaring that Defendants violated the identified state laws, and awarding declaratory and injunctive relief to remedy such violations;

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

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 Plaintiffs and members of the Classes for all improperly billed amounts; and

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

JURY DEMAND

Plaintiffs demand trial by jury on all issues so triable.

Dated: December 28, 2012

Respectfully submitted,

/s/ Steven A. Schwartz
Steven A. Schwartz (Pa. I.D No. 50579)
Alison G. Gushue (Pa. I.D. No. 203669)
CHIMICLES & TIKELLIS LLP
361 West Lancaster Avenue
Haverford, PA 19041
Tel: 610-642-8500
Fax: 610-649-3633
Email: SAS@Chimicles.com
AGG@Chimicles.com

D. Brian Hufford
Robert J. Axelrod
Susan J. Weiswasser
Anthony J. Maul
POMERANTZ GROSSMAN HUFFORD DAHLSTROM & GROSS LLP
600 Third Avenue
New York, NY 10016
212.661.1100
212.661.8665 (fax)

Vincent N. Buttaci
John W. Leardi
Paul D. Werner
BUTTACI & LEARDI, LLC
212 Carnegie Center, Suite 206
Princeton, NJ 08540
609.919.6311
609.524.2575 (fax)

Gerald McGonagle
David Spencer
McGONAGLE SPENCER, P.C.
1533 Locust Street
Kansas City, MO 64108
816.221.2222
816.221.2245 (fax)

Paul M. Weiss
Jeffrey A. Leon
COMPLEX LITIGATION GROUP LLC
513 Central Avenue
Suite 300
Highland Park, IL 60035
847.433.4500
847.433.2500 (fax)

James E. Cecchi
CARELLA, BYRNE, CECCHI, OLSTEIN, BRODY & AGNELLO
5 Becker Farm Road
Roseland, NJ 07068
973.994.1700
973.994.1744 (fax)

Joe R. Whatley, Jr.
Edith M. Kallas
WHATLEY KALLAS
380 Madison, 23rd Floor
New York, NY 10017
212.447.7060
212.447.7019 (fax)

Counsel for Plaintiffs and the Putative Classes