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UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

ASSOCIATION OF NEW JERSEY CHIROPRACTORS and NEW YORK CHIROPRACTIC COUNCIL, on their own behalf and in a representational capacity on behalf of their respective members, and DONNA RESTIVO, D.C., TODD CARNUCCI, D.C., CHRISTOPHER FOGLIA, D.C., PETER MANZ, D.C., and LEON EGOZI, M.D, individually, and on behalf of all others similarly situated,

Plaintiffs,

- against -

AETNA, INC., AETNA HEALTH INC., AETNA HEALTH INC. (DE), AETNA HEALTH INC. (PA), AETNA HEALTH PLANS OF NEW JERSEY, INC., AETNA HEALTH MANAGEMENT, INC., AETNA HEALTH ADMINISTRATORS, LLC, AETNA HEALTH MANAGEMENT, LLC, AETNA LIFE INSURANCE COMPANY, CORPORATE HEALTH INSURANCE, INC., and AETNA INSURANCE COMPANY OF CONNECTICUT,

Defendants.

Civil Action No. _____

CLASS ACTION COMPLAINT
and DEMAND FOR JURY TRIAL

Plaintiffs Donna Restivo, D.C. ("Restivo"), Todd Carnucci, D.C. ("Carnucci"), Christopher Foglia, D.C. ("Foglia"), Peter Manz, D.C. ("Manz") and Leon Egozi, M.D. ("Egozi"), on behalf of themselves and all others similarly situated, and Plaintiffs Association of New Jersey Chiropractors ("ANJC") and New York Chiropractic Council ("NYCC"), on behalf of themselves and on behalf of their respective members, by way of a Class Action Complaint (the "Complaint"), against Defendants Aetna, Inc., Aetna Health Inc., Aetna Health Inc. (DE), Aetna Health Inc. (PA), Aetna Health Plans of New Jersey, Inc., Aetna Health Management, Inc., Aetna Health Administrators, LLC, Aetna Health Management, LLC, Aetna Life Insurance Company, Corporate Health Insurance, Inc., and Aetna Insurance Company of Connecticut (collectively "Aetna" or "Defendants"), 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. Plaintiffs Restivo, Carnucci, Foglia, Manz, and Egozi (the "Individual Plaintiffs") are licensed health care providers who seek to represent licensed health care providers affected by Defendants' conduct as alleged herein (the "Class"). Plaintiffs ANJC and NYCC (the "Association Plaintiffs") are chiropractic professional associations that seek to represent their members, all of whom are licensed chiropractors (the "Association Plaintiffs' Members"). The Individual Plaintiffs and the Association Plaintiffs allege systemic and repeated violations by Aetna of the Employee Retirement Income Security Act of 1974 ("ERISA") and the Racketeer Influenced and Corrupt Organizations Act ("RICO") as described more fully herein.

2. Defendant Aetna offers, underwrites, and administers commercial health plans

("Plan" or "Plans"), through which health care expenses incurred by Plan insureds ("Aetna Insureds") for services and/or products covered by the Plans ("Covered Services") are reimbursed by and/or through Aetna, subject to the Plan's terms, conditions, and limitations.

3. At all times relevant hereto, the Individual Plaintiffs and the Association Plaintiffs' Members regularly submitted claims for reimbursement to Aetna with respect to services they provided to Aetna Insureds. In each case, the Individual Plaintiffs and the Association Plaintiffs' Members submitted claims for benefits on behalf of Aetna Insureds who were their patients directly to Aetna, and Aetna paid benefits for such services directly to the Individual Plaintiffs and the Association Plaintiffs' Members. In so doing, Aetna first determined that the treatments in question were in fact Covered Services under the terms and conditions of each Aetna Insured's respective Plan.

4. The vast majority of the Aetna Insureds on whose behalf the Individual Plaintiffs and the Association Plaintiffs' Members submitted claims and were paid benefits, were covered by Plans offered, underwritten, or administered by Aetna as part of a private employee welfare benefit plan governed by ERISA. ERISA governs all such private employee welfare benefit plans, whether they are fully-insured or self-funded, and is estimated to include more than 170 million insureds nationwide. ERISA-exempt plans include those which are issued by governmental agencies or churches, or for plans acquired by individuals, and not through an employer.

5. Because the benefit payments to the Individual Plaintiffs were made based on Aetna's evaluation and assessment of the terms and conditions of ERISA Plans, ERISA governs the adjudication of these benefit payments. Further, because Aetna paid the benefits directly to the Individual Plaintiffs and the Association Plaintiffs' Members pursuant to assignments they

had received from Aetna Insureds, the Individual Plaintiffs and the Association Plaintiffs' Members are deemed to be beneficiaries under ERISA with standing to assert rights and protections under this statute.

6. Aetna established and maintains a Special Investigations Unit ("Aetna's SIU") to detect, investigate, and prevent false or fraudulent insurance claims. The primary means by which Aetna's SIU identifies false or fraudulent insurance claims is by conducting Post Payment Audits. A "Post Payment Audit" refers to a retrospective review of previously paid insurance benefits to evaluate whether payments for Covered Services were properly made to Aetna Insureds, or healthcare providers acting as assignees ("Providers"), under a Plan administered by Aetna. The overwhelming majority (approximately 80%) of Aetna's Post Payment Audits are Provider-based, meaning that the claims reviewed are submitted by and paid to Providers. In selecting Providers to retroactively audit, Aetna relies upon a variety of complex statistical analyses and data mining to identify Providers or practices that exhibit potentially problematic or non-traditional billing patterns ("Provider Profiling").

7. Aetna's SIU conducts, and all times relevant hereto conducted, Post Payment Audits of chiropractic physicians throughout the United States ("Chiropractic Post Payment Audits"), including the Plaintiffs Restivo, Carnucci, Foglia and Manz, and the Association Plaintiffs' Members, by and through offices and personnel located in the State of New Jersey. In conducting these Chiropractic Post Payment Audits, Aetna's SIU works in conjunction with the National Health Care Anti-Fraud Association (the "NHCAA") and International Business Machines Corporation ("IBM"). Specifically, the NHCAA, of which Aetna and certain of its employees are members, and IBM, with whom Aetna jointly developed auditing software, assist Aetna and Aetna's SIU in their development and implementation of policies and procedures

relative to Aetna's Chiropractic Post Payment Audits, including the manner in which Provider Profiling is performed, the manner in which Chiropractic Post Payment Audits are performed, what findings indicate that services for which payment was previously made were not "covered" ("Retroactive Benefit Determinations"), and what actions Aetna undertakes to recover payments ("Recoupment Efforts").

8. After having paid benefits on behalf of its Insureds to the Individual Plaintiffs and many of the Association Plaintiffs' Members for a substantial period of time -- thus having determined that their services were Covered Services under the terms and conditions of the applicable Plans -- Aetna conducted Post Payment Audits of each of the Individual Plaintiffs and many of the Association Plaintiffs' Members. As a result of the purported findings relative to each one of these Post Payment Audits, Aetna made Retroactive Benefit Determinations with regard to services previously paid to the Individual Plaintiffs and many of the Association Plaintiffs' Members on behalf of its Insureds. In doing so, Aetna reversed its prior coverage determinations and represented that the Individual Plaintiffs and many of the Association Plaintiffs' Members "owed" Aetna money for previously paid benefits that were now deemed not to be for Covered Services under the Plans of the Aetna Insureds they treated.

9. Each of the Individual Plaintiffs received similar demand letters from Aetna, representing that its SIU had determined that they had been overpaid benefits during a prior period of time, and thereby demanded payment of specified sums. For example: (a) by letter dated August 8, 2007, Aetna demanded that Dr. Restivo repay it a total of $50,650.02 relating to services she had provided during the period from January 2006 to July 2007; (b) by letter dated September 10, 2008, Aetna demanded that Dr. Carnucci repay it a total of $597,643.00 relating to services he had provided during the period from September 2002 to March 2008; (c) by letter

dated April 24, 2008, Aetna demanded that Dr. Foglia repay it a total of $15,609.88 relating to services he had provided during the period from April 8, 2006 to March 12, 2008; (d) by letter dated August 25, 2008, Aetna demanded that Dr. Manz repay it a total of $20,290.09 relating to services he had provided during the period from July 31, 2006 through July 31, 2008; and (e) by letter dated November 27, 2007, Aetna demanded that Dr. Egozi repay it a total of $299,796.22 relating to services dating back to 2005. The Individual Plaintiffs have subsequently been subjected to numerous communications and other Recoupment Efforts from Aetna seeking to compel their payment of the demanded amounts; this includes, but is not limited to, threatening correspondence from Barbara Tancredi, outside legal counsel to Aetna's SIU, and "Pre-Payment Review," a process by which every claim a Provider submits to Aetna for care rendered to Aetna's Insureds is purportedly reviewed prior to payment and, in practice, uniformly denied regardless of the validity of the claim, and without providing a means by which to appeal. While Drs. Restivo, Carnucci, Manz and Egozi are continuing to fight Aetna's demands, Dr. Foglia ultimately paid Aetna $1,915 to settle, after having been threatened with Pre-Payment Review, which would have effectively put him out of business. By and through this action, Dr. Foglia is seeking to rescind his prior settlement and to compel Aetna to return his payment.

10. Based on information and belief, Aetna has made and is continuing to make similar demands for repayment of previously paid benefits, including demands of many of the Association Plaintiffs' Members. Aetna's internal records will reflect: (a) the number of Post Payment Audits it has conducted or is conducting on Providers throughout the country; (b) the number of Providers subject to Retroactive Benefit Determinations made as a result of these Post Payment Audits; (c) Aetna's use of Recoupment Efforts, including Pre-Payment Review, to extract money from Providers; and (d) the amount of money Aetna recovered from Providers.

The Individual Plaintiffs and the Association Plaintiffs seek injunctive and equitable relief to halt Aetna's practice of making improper Retroactive Benefit Determinations and to compel Aetna to repay Providers for the amounts they were coerced to pay as a result of Aetna's improper Recoupment Efforts.

11. Drs. Restivo, Carnucci, and Foglia are -- and, during the Class Period, as defined below, were -- duly licensed practicing chiropractors who have not entered into a contract with Aetna to be part of its provider networks. As non-participating ("Nonpar") providers, Drs. Restivo, Carnucci, and Foglia did not agree to accept internal policies adopted by Aetna limiting what chiropractic services they could or could not perform or to accept discounted rates for services provided to Aetna Insureds. As such, they were free to perform generally accepted chiropractic services and were entitled to charge their usual and customary rates for such services. Moreover, Aetna must pay benefits to Drs. Restivo, Carnucci, and Foglia, or their patients, pursuant to the terms and condition of Aetna's Plans. As Nonpar providers, the Aetna Insureds who were treated by Drs. Restivo, Carnucci, and Foglia owe them for the full amount of their bill once a service is provided. To the extent Aetna has paid all or a part of that bill as the patients' insurer, that amount is no longer owed by the patient. However, to the extent Aetna demands and obtains any "refund" from Drs. Restivo, Carnucci, and Foglia based upon Retroactive Benefit Determinations, those amounts will now be owed to Drs. Restivo, Carnucci, and Foglia by their patients and they will be entitled to bill them for those amounts.

12. Dr. Manz is a licensed chiropractor who entered into a Physician Group Agreement with Aetna, and Dr. Egozi is a licensed surgeon who entered into a Specialist Physician Agreement with Aetna. Collectively, these agreements are referred to herein as a Provider Group Agreement, or "PGA." As signatories to PGAs, Drs. Manz and Egozi are

participating (or "Par") providers. Pursuant to their respective PGAs with Aetna, Drs. Manz and Egozi agreed to provide health care services to Aetna Insureds for an agreed-upon discounted rate. The PGA, however, limits Drs. Manz and Egozi's reimbursement to "Covered Services." Dr. Manz's PGA defines "Covered Services" as [t]hose Medically Necessary Services (including Emergency Services) which a Member is entitled to receive under the terms and conditions of a Plan," with "Plan" defined as "[a]ny health benefit product, plan or program issued, administered, or serviced by [Aetna] or one of its Affiliates, including but not limited to, HIC, preferred provider organization, indemnity, Medicaid, Medicare and Workers' Compensation." Similarly, Dr. Egozi's PGA defines "Covered Services" as "[t]hose health care services for which a Member is entitled to receive coverage under the terms and conditions of a Plan." with "Plan" defined as "[a] Member's health care benefits as set forth in the Member's Summary Plan Description, Certificate of Coverage or other applicable coverage document." A "Summary Plan Description" (or "SPD") is a term of art referring to a document required under ERISA which summarizes the material terms and conditions of an employee benefit plan.

13. Pursuant to the terms and conditions of their contracts with Aetna, Drs. Manz and Egozi are permitted to bill or charge their Aetna patients for "services that are not Covered Services," so long as the Plan or Aetna confirms that the service is not covered and the Member had agreed in advance, in writing, that he or she would pay for any services that were deemed not to be Covered Services by Aetna. The standard practice of Drs. Manz and Egozi is to have each of their respective patients sign an acknowledgment in advance of providing any health care services that they are liable and will pay for the cost of any services that are not Covered Services and not paid for by Aetna. As a result, to the extent Aetna demands and obtains a "refund" from either Dr. Manz or Dr. Egozi based upon Retroactive Benefit Determinations, Drs. Manz and

Egozi are entitled to balance bill Aetna's Insureds for the unpaid amounts.

14. The Individual Plaintiffs all obtain assignments from their Aetna patients that give the Individual Plaintiffs the right to bill Aetna directly for their services and to receive payment from Aetna directly. Aetna's PGAs further explicitly require Par providers such as Drs. Manz and Egozi to obtain from their patients "signed assignments of benefits authorizing payment for Covered Services to be made directly to Group or its designee." Moreover, Aetna accepted these assignments as being valid by dealing directly with the Individual Plaintiffs and paying them directly. Accordingly, Aetna waived any assertion concerning the validity of the assignments and is otherwise estopped from asserting such objections. The Individual Plaintiffs were specifically authorized by Aetna Insureds to represent them in pursuing this action against Aetna. As a result, the Individual Plaintiffs have standing to pursue the ERISA claims asserted.

15. Aetna's determination that the services provided by the Individual Plaintiffs are not covered under Aetna's health care plans, as reflected in their demand letters, represents a retrospective denial of benefits, subject to the rules and regulations governing ERISA plans.

16. Aetna intentionally mischaracterized its recoupment demands as involving non-ERISA issues so as to avoid its duties and responsibilities under ERISA. In ignoring or rejecting the efforts by Plaintiffs and other members of the Classes identified below to pursue ERISA appeals of its recoupment demands, Aetna further engaged in an intentional effort to mislead providers into believing that ERISA does not apply, so as to avoid its duties and responsibilities under ERISA and to discourage valid lawsuits such as this one.

17. Aetna has no legal basis for demanding recoupment from providers in the manner in which it has and, in doing so, it violates its obligations under ERISA. Further, Aetna's effort to obtain recoupment is a demand for restitution. Under ERISA, Aetna is limited to seeking

equitable relief for such restitution, and it fails to satisfy the requirements for such relief.

18. As a party that makes benefit determinations and resolves appeals and grievances on behalf of a patient's Plan, Aetna assumes the role of a fiduciary under ERISA, whereby it owes its Insureds -- and their assignees -- the highest duties of good faith and fair dealing. By taking improper steps to reverse prior approvals of benefits and thereby impose financial obligations on its Insureds, Aetna violated its fiduciary obligations.

19. Even assuming that Aetna had a valid basis for seeking reimbursement under its Plans, it failed to take the proper steps under ERISA to do so. To have a valid basis for pursuing repayment, Aetna must issue revised Explanations of Benefits ("EOBs") to the patients whose services are at issue, with adequate disclosure of proper procedures for appealing such an adverse benefit determination. It further is required to provide, upon request of the patients or their authorized representatives, including the Individual Plaintiffs here, copies of all relevant plan materials, including SPDs, relating to its adverse benefit determination. Aetna failed to do so, in violation of ERISA, and is precluded from seeking repayment.

20. The purported basis upon which Aetna sought reimbursement, and its continued application of such policies with regard to ongoing and future health care services, is also flawed and without valid support. For Drs. Restivo, Carnucci, Manz and Foglia, Aetna retrospectively adopted Clinical Policy Bulletins ("CPBs") whereby it deems various covered chiropractic services to be not covered due to a lack of clinical efficacy across the board or pursuant to the experimental and investigational exclusion in Aetna's health care policies. As detailed herein, however, each of the procedures at issue are generally accepted services in the chiropractic community and do not fall within the terms and conditions of the experimental and investigational exclusion of Aetna's health care plans, but are reimbursable services.

21. For Dr. Egozi, Aetna claims that he owes reimbursement because he purportedly had performed surgeries without first complying with certain of Aetna's CPBs. Yet, Dr. Egozi has been reimbursed for the services at issue for a number of years, with frequent communications and appeals to Aetna concerning coverage issues, such that Aetna knew full well exactly what procedures were being performed and in what circumstances before it had provided reimbursement. Moreover, Dr. Egozi was in full compliance with Aetna's CPBs in any event, such that his reimbursements were entirely proper regardless of Aetna's CPBs.

22. The Association Plaintiffs bring this case on their own behalf and/or on behalf of their members who have been injured as a result of the egregious acts and practices of Aetna as set forth in the Complaint.. The Association Plaintiffs are dedicated to advocating for the rights of providers and patients alike for the delivery of the highest quality of health care. The Association Plaintiffs were also directly injured by the challenged conduct set forth herein. As a result of Aetna's unlawful practices, the Association Plaintiffs were required to devote substantial time and resources counseling its members on the auditing and recoupment practices at issue, monitoring the payment practices of Aetna, corresponding with Aetna, advocating on its members' behalf, and communicating with regulators concerning Aetna's misconduct, among other things. Accordingly, the Association Plaintiffs allege violations of ERISA and RICO on behalf of their members, seek appropriate equitable and injunctive relief, and further seek appropriate compensatory damages for their own injuries.

23. Because Aetna's actions were improper and without a valid legal foundation, Plaintiffs seek (1) to enjoin Aetna from imposing improper Retroactive Benefit Denials on Plaintiffs and all others similarly situated; (2) to enjoin Aetna from engaging in improper Recoupment Efforts relative to the Plaintiffs and all others similarly situated; (3) to order Aetna

to return to all Providers any funds it improperly collected during the Class Period based on its Recoupment Efforts; (4) to compel Aetna to find that the chiropractic services identified herein are Covered Services under the Plans its offers, underwrites, and/or administers; and (5) to compel Aetna to find that the surgical procedures as provided by Dr. Egozi are Covered Services under the Plans its offers, underwrites, and/or administers.

THE PLAINTIFFS

24. Dr. Restivo is a licensed chiropractor, with over 25 years of experience both as a chiropractor and in the Science of Nutritional Analysis, whose diverse chiropractic, academic, science, and research background brings a high level of clinical strength to her diagnosis, treatment, and prevention of a variety of spinal disorders, injuries, and disease. Dr. Restivo's practice also focuses on her patients' general health and wellness. A 1982 graduate of Palmer College of Chiropractic, a world-renowned chiropractic college, Plaintiff Restivo's training exceeds the strict educational standards set by state and national chiropractic boards, and she is a Diplomate of the National Board of Chiropractic Examiners. She maintains her practice in Mahopac, New York.

25. Dr. Carnucci has been licensed to practice chiropractic in New Jersey since 2000, and currently serves as the Clinic Director and CEO of Westfield Health and Rehabilitation, LLC, a multidisciplinary practice providing chiropractic and physical therapy services in a wide range of clinical applications including, but not limited to, sports-related injuries and acute traumatic spinal injuries. Dr. Carnucci received his doctor of chiropractic in 2000 from Life University in Marietta, Georgia, and his bachelor's degree in 1996 from Bloomfield College in Bloomfield, New Jersey. Dr. Carnucci also has postgraduate training in: Diversified Adjustment Technique, Cox Lumbar Disc Flexion/Distraction Technique, Thompson Drop Point Technique,

Toggle/Upper Cervical Technique, Activator Methods, Impulse Adjuster, Comprehensive Index and Soft-Tissue Damage Scale, AMA Impairment Rating, Kennedy Decompression Technique, Manipulation Under Anesthesia ("MUA"), and Nerve Conduction Velocity ("NCV") Testing. Dr. Carnucci is a staff doctor at Clifton Surgery Center in Clifton, New Jersey, and is an active member of both the ANJC and the American Spinal Care Association.

26. Dr. Foglia has been a licensed chiropractor in New York since 1993. Receiving a B.S. in Biological Sciences from the State University of New York, Stony Brook, in 1988, Dr. Foglia became a certified Lab Technologist, and worked as Assistant Supervisor at Brunswick Hospital before receiving his Doctor of Chiropractic degree from New York Chiropractic College. A Diplomate of the National Board of Chiropractic Examiners and licensed by the New York Board of Regents, Dr. Foglia practices in Bohemia, New York.

27. Dr. Manz has been a licensed chiropractor since 1988, first in Michigan and then in Ohio, where he has run the Midwest Chiropractic Center in Columbus since 1989. He completed substantial coursework in Biology (working towards a bachelor's degree) at Wayne State University in 1984, and then graduated from Palmer Chiropractic College in 1988. Dr. Manz was Vice-Chairman of the Chiropractic Department and a Member of the Credentialing Committee for the Columbus Community Hospital until it closed several years ago, and is a former District 9 Director (Central Ohio) for the Ohio Chiropractic Association.

28. Dr. Egozi is a surgeon who received his bachelor's degree from the University of Miami in 1983, his medical degree in 1987 from the Medical College of Wisconsin, and completed his internship and residency in 1992 with the Albert Einstein College of Medicine at the Flushing Hospital Medical Center. He is Board Certified by the American Board of Surgery and is a Diplomate in General Surgery. Further, Dr. Egozi is a Fellow of the American College

of Surgeons ("F.A.C.S."). Dr. Egozi has extensive research experience, and has frequently made presentations at medical conferences and written for medical journals.

29. Dr. Egozi's practice is based in Miami, Florida, and he is the Surgical Director for the American Institute for Hyperhidrosis ("AIH"). AIH provides back-office administrative services for Dr. Egozi, including administrative and billing services relating to the provision of Endoscopic Thoracic Sympathectomy ("ETS") surgery, a procedure provided by Dr. Egozi to numerous patients who suffer from excessive sweating ("hyperhidrosis"). For patients who suffer from debilitating cases of hyperhidrosis, Dr. Egozi specializes in the use of a sophisticated ETS operative procedure involving a reverse clamping technique ("ETS-C"). With ETS-C, clamps are applied to the overactive nerves in the chest cavity which are responsible for the excessive sweating. This procedure has proven highly successful and life-altering for Dr. Egozi's patients. The rates billed by Dr. Egozi are intended to cover the time and expenses both for his own direct services as well as for the back-office administrative services provided by AIH, which are an essential part of his practice. As a result, any discussion of Dr. Egozi's billings or Aetna's payments for his services, as detailed herein, includes both Dr. Egozi and AIH.

30. The Association of New Jersey Chiropractors ("ANJC") is a not-for-profit professional association whose membership consists exclusively of individuals licensed to practice chiropractic in the State of New Jersey. The ANJC was formed by the merger of six separate and distinct chiropractic professional organizations, including the New Jersey Chiropractic Society, into one single, unified, statewide voice. The mission of the ANJC is to embrace, protect, preserve, and promote the science, art, and philosophy of chiropractic in the State of New Jersey and the professional welfare of its approximately 1,500 members. Headquartered in Branchburg, New Jersey, the ANJC serves as the primary information resource

regarding the benefits of chiropractic care and wellness in the State. Its primary goal is to advocate and represent the interests of New Jersey chiropractors and their patients in New Jersey, as it works toward improving the quality of life for the public and the more than one million patients seeing chiropractors throughout New Jersey on a regular basis.

31. The New York Chiropractic Council is a chiropractic association based in Rosedale, New York. Its members consist of more than 600 chiropractors and chiropractic students. The NYCC's adopted mission "is to direct people to the realization that healing comes from within; and that ultimately the promotion of health and wellness is superior to the treatment of disease." Further, it has adopted the following purposes:

> The purpose of the COUNCIL is to promote the basic philosophy, science and art of chiropractic. The COUNCIL has been formed as well for the following reasons:
>
> To protect the welfare of its members to practice chiropractic without compromise, and with parity and respect;
>
> To protect the public`s ability to receive chiropractic without prejudice, ridicule or financial penalty from any individual, group or profession;
>
> To conduct educational seminars, lectures and meetings within the profession and the public in accordance with our stated objectives;
>
> To keep chiropractic separate and distinct from all other professions;
>
> To foster interprofessional relations based upon mutual respect and a clear understanding of the basic Philosophy, Science and Art of Chiropractic.

32. As part of their work, the Association Plaintiffs assist members who have been subjected to improper or overzealous audits by insurance companies, seek to negotiate with insurers in an effort to advance the interests of chiropractors, and work with legislatures and regulators with respect to chiropractic legislation and regulations.

33. The Association Plaintiffs bring this action to obtain appropriate equitable and

injunctive relief for their members in combating Aetna's abusive practices as detailed herein, and to obtain compensation for their expenditures in time and money assisting members in dealing with such improper practices. The Association Plaintiffs have individual standing as they have been injured by Aetna's wrongful conduct as alleged herein. They have expended considerable time and resources helping their members deal with issues concerning Aetna's improper Chiropractic Post Payment Audits and Recoupment Efforts, including its Pre-Payment Review practices. The Association Plaintiffs also have associational standing on behalf of their members who have claims against Aetna for the violations alleged in this Complaint. In addition to the redress they seek for their own injury, and where their members are entitled to do so and the claims for relief stated herein otherwise permit, the Association Plaintiffs seek declaratory and injunctive relief necessary to protect the interests of their members.

THE DEFENDANTS

34. Aetna, through its parent corporation, Aetna, Inc., or one of its wholly owned and controlled subsidiaries, offers, insures, underwrites, and administers commercial health benefits, including those of the Aetna Insureds for whom the Individual Plaintiffs and many of the Association Plaintiffs' Members have provided health care services, as detailed herein. At all times relevant hereto Aetna was authorized to transact business in the New Jersey, actually transacted business in the New Jersey, and maintained offices in the State of New Jersey.

35. "Aetna" is a brand name used for products and services provided by one or more of the Aetna group of subsidiaries that offer, underwrite, or administer benefits. When used in this Complaint, "Aetna" includes all Aetna 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, all of the Defendants are functional ERISA fiduciaries and, as such, they must comply with fiduciary standards. In the Complaint, "Aetna" refers to all named Defendants and all predecessors, successors and subsidiaries to which these allegations pertain.

36. Aetna's SIU conducts its Chiropractic Post Payment Audits by and through Aetna's offices and personnel located in or around New Jersey cities of Iselin, Cranbury, and Princeton. And while Aetna's New Jersey SIU offices and personnel coordinate with Aetna SIU offices and personnel in Hartford, Connecticut, and Lexington, Kentucky, management, control, and supervision of all Chiropractic Post Payment Audits are centralized in Aetna's New Jersey SIU offices or carried out by Aetna's New Jersey SIU personnel. Additionally, all policies and procedures relative to Aetna's Chiropractic Post Payment Audits, including the manner in which Provider Profiling is performed, the manner in which Chiropractic Post Payment Audits are performed, what findings result in Retroactive Benefit Determinations, and what Recoupment Efforts Aetna undertakes to recover sums previously paid, including Pre-Payment Review, are performed in Aetna's New Jersey SIU offices or by Aetna's New Jersey SIU personnel.

JURISDICTION AND VENUE

37. Aetna's actions in administering employer-sponsored health care plans, including determining reimbursement for providers who perform health care services to Aetna Insureds pursuant to the terms and conditions of the health care plans, are governed by ERISA, 29 U.S.C. §§ 1001-1461. Plaintiffs assert subject matter jurisdiction for their ERISA and RICO claims under 28 U.S.C. § 1331 (federal subject matter jurisdiction), 29 U.S.C. § 1132(e) (ERISA), and 18 U.S.C. §§ 1965(b) and (d) (RICO).

38. Venue is appropriate in this District for Plaintiffs' claims under 28 U.S.C. § 1391, 18 U.S.C. § 1965, and 29 U.S.C. § 1132(e)(2) because: (i) Aetna resides, is found, has an agent,

and transacts business in this District, and (ii) Aetna 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 New Jersey. Further, the inappropriate conduct alleged herein, including Aetna's Chiropractic Post Payment Audits, Retroactive Benefit Determinations, Recoupment Efforts, and Pre-Payment Review, all occur in Aetna's New Jersey SIU offices or are ordered by Aetna's New Jersey SIU.

OVERVIEW OF PLAINTIFFS' LEGAL CLAIMS

39. As the company (or companies) that offers, underwrites, and administers the employee benefit plans by and through which a number of Plaintiffs' patients (and Aetna Insureds) received their insurance, Aetna is subject to ERISA, and its governing regulations. Further, due to the role Aetna 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, Aetna assumed the role of a fiduciary under ERISA. Under ERISA, Aetna cannot deny coverage for such services unless the applicable Plans expressly include an exclusion that specifies that such services are not Covered Services.

40. Under ERISA, Aetna is required, among other things, to comply with the terms and conditions of its Plans; to accord its Insureds or their Providers an opportunity to obtain a "full and fair review" of any denied or reduced reimbursement; and to make appropriate and non-misleading disclosures to 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.

41. In offering and administering its Plans, Aetna assumes the role of "Plan Administrator," as that term is defined under ERISA, in that it interprets and applies the Plan terms, makes all coverage decisions, and provides for payment to members and/or their Providers. As the Plan Administrator, Aetna also assumes various obligations specified under ERISA. These obligations include providing its members with an 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.

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

43. Aetna violated ERISA and breached its fiduciary duties by failing to disclose the reimbursement rules it uses to reduce members' benefits, by making a retroactive benefit claim denial without proper disclosure or following required procedures, by seeking to impose new policies after-the-fact in an effort to compel payments by providers, by improperly excluding benefits for safe and effective chiropractic services based on an incorrect determination that they were experimental and investigational, by improperly excluding benefits for ETS services, and by failing to fulfill its obligations of good faith, due care, and loyalty.

44. With respect to all its Plans, Aetna is obligated to its members and their providers

to provide specific health care benefits and reimbursements. As detailed herein, Aetna breached, and continues to breach, its obligations to Plaintiffs and the Class, and in so doing violated ERISA.

45. Aetna's scheme or artifice to defraud millions of dollars from Providers through its Post Payment Audits, Retroactive Benefit Determinations, Recoupment Efforts, and Pre-Payment review further violates RICO. In order to maximize its profits, Aetna knowingly demanded recoupment from numerous providers when it knew or should have known it had no basis for doing so, making demands, threatening litigation, imposing Pre-Payment Review and forcing numerous providers to settle in order to avoid further retribution.

46. With respect to all its Plans, Aetna is obligated to its Insureds and their Providers to provide specific health care benefits and reimbursements. As detailed herein, Aetna knowingly breached, and continues to knowingly breach, its obligations to the Plaintiffs and the Class, and in so doing has violated ERISA and RICO.

PLAINTIFF RESTIVO'S EXPERIENCE WITH AETNA'S GROUP HEALTH PLANS

47. Plaintiff Restivo has been providing medically necessary chiropractic services to Aetna Insureds, as a Nonpar provider, throughout her 25-year career. During the bulk of that time, Aetna recognized that the services she provided were valid and appropriate, and reimbursed her based on its usual, customary and reasonable rates, pursuant to the terms and conditions of its health care plans.

48. On August 8, 2007, Plaintiff Restivo's attorney received a letter from Aetna's Special Investigations Unit, based in Cranbury, New Jersey (the "8/8/07 Letter"). It stated that it had "completed a review of claims submitted by your client's office to Aetna Life Insurance

Company or one of its affiliates (collectively 'Aetna')" during the period January 2006 to July 2007, and concluded that it had overpaid Plaintiff Restivo by an amount of $50,650.02.

49. The 8/8/07 Letter identified a number of reasons for why Aetna claimed it had overpaid Plaintiff Restivo. None of these reasons is valid. Moreover, given that there is no basis for Aetna to allege, and it did not allege, that Plaintiff Restivo had intentionally misled it with regard to Aetna's prior benefit determinations, Aetna has no legal basis for seeking restitution even assuming its conclusions regarding certain billing practices by Plaintiff Restivo were valid.

50. By way of the 8/8/07 Letter, Aetna also improperly sought to reconsider a benefit decision that had previously been made under ERISA. In seeking to recalculate benefits based on claims filed under ERISA plans, Aetna was required to comply with ERISA and its underlying regulations relating to claims denials. It failed to do so, in violation of its statutory and fiduciary obligations.

51. The 8/08/07 Letter included the following claims for restitution:

a. Aetna asserted that Plaintiff Restivo had improperly billed CPT Code 97140 for both joint and soft tissue manual techniques when rendered in the same region and on the same day as a Chiropractic Manipulation Therapy ("CMT"). It contended that it had reviewed all of the documentation relating to billings for CPT Code 97140 and it "does not clearly identify the body regions addressed by the CMT or CPT code 97140." Therefore, Aetna stated that it had overpaid Plaintiff Restivo by $26,393, which represented 100% of the amount Plaintiff Restivo had been reimbursed for those services during the period covered by the investigation. Hereinafter, this shall be referred to as the "97140/CMT Issue."

b. Aetna further asserted that Plaintiff Restivo had improperly used CPT Code 97022, Whirlpool, to indicate use of a Dry Hydrotherapy Bed, stating that she should have

used CPT Code 97039 for this service, which relates to an "unlisted modality." Aetna then stated that it considers "Aquamassage" as "experimental and investigational per our Clinical Policy Bulletin - #699 Dry Hydrotherapy (Hydromassage, Aquamassage, Water Massage), because there is insufficient scientific evidence on the effectiveness of this intervention." The letter stated that Aetna deemed $8,746.24 to be overpaid for these services, representing 100% of what it had reimbursed Plaintiff Restivo during the investigation period for CPT Code 97022. Hereinafter, this shall be referred to as the "Aqua Massage Issue."

c. Aetna further asserted that Plaintiff Restivo's billing for CPT Code 97012, Mechanical Traction, for which she used Intersegmental Traction Tables, was improper as it was not a covered service pursuant to Aetna's Clinical Policy Bulletin - #569 Lumbar Traction Devices. According to Aetna, Auto Traction was deemed to be "experimental and investigational because of a lack of evidence of its efficacy, particularly in comparison with other forms of traction." Aetna stated that it had overpaid Plaintiff Restivo in the amount of $8,792.83 for these services, and asked that she "discontinue billing Aetna when utilizing this device." Hereinafter, this shall be referred to as the "Auto Traction Issue."

d. Aetna further stated that Plaintiff Restivo's billing for CPT Code 95999 for Surface Scanning Electromyography ("SEMG") was improper, as SEMG was not a covered service. According to Aetna, it "considers the use of SEMGs experimental and investigational per our Clinical Policy Bulletin - #112 Surface Scanning and Macro Electromyography because the reliability and validity of these tests have not been established." Aetna stated that it had overpaid Plaintiff Restivo $4,481 for these services, and asked that she "discontinue billing Aetna for this procedure." Hereinafter, this shall be referred to as the "SEMG Issue."

e. Aetna further expressed "concern" over Plaintiff Restivo's billing of a

5 region CMT (CPT Code 98942). According to Aetna, its review of the treatment records indicated that 109 of the 157 times Plaintiff Restivo had billed for 5 region CMT, or 69%, should have been more appropriately coded CPT Code 98941 for 3-4 region CMT. Extrapolating this percentage to the 293 times that Plaintiff Restivo had billed CPT Code 98942, Aetna asserted that it had reconsidered its benefit determination and deemed 202 of those times to be covered only by CPT Code 98941, reflecting an overpayment of $2,236.75. Hereinafter, this shall be referred to as the "5 Region CMT Issue."

f. Finally, Aetna stated that, as of August 17, 2007, it "will require that all claims [Plaintiff Restivo] submits for reimbursement under CPT codes 98942, 95999, 97022, 97410 and 97012 be reviewed prior to payment." Hereinafter, this shall be referred to as the "Pre-Payment Review Issue."

52. Aetna then stated in its letter that it was forwarding a password-protected disk to Plaintiff Restivo identifying the specific alleged overpayments and asked that it be contacted "to discuss this overpayment" and seek "an amicable resolution of this matter." Aetna did not identify any further means by which Plaintiff Restivo could pursue an internal appeal of Aetna's new benefit denials.

53. Aetna had not overpaid Plaintiff Restivo and, further, had no valid basis for any of its decisions to seek restitution for the alleged overpayments. Moreover, Aetna violated ERISA by issuing revised benefit determinations for literally hundreds of services without providing the necessary disclosures relating to those decisions.

54. Although Aetna was obligated to do so, with regard to each of its revised benefit determinations cited to in its 8/8/07 Letter, Aetna failed to provide a "full and fair review" of denied claims pursuant to 29 U.S.C. § 1133 (and the regulations promulgated thereunder) for

Plaintiff Restivo. Among other things, Aetna denied claims in a manner that was inconsistent with or unauthorized by the terms of Members' EOCs and SPDs, as well as by failing to disclose the basis for its determinations, its methodology and other critical information relating to its benefit denials, including the right to appeal its revised claims denials.

55. ERISA and its implementing regulations set forth standards for claim procedures, appeals, and notice to Members. By engaging in the conduct described herein, including using improper, invalid and undisclosed policies relating to chiropractic services, issuing revised benefit denials without proper explanations or disclosure of administrative appeal or grievance procedures, making baseless threats regarding overpayments and referrals to collection agencies, and causing other systematic benefit reductions without disclosure or authority under the plans, Aetna violated ERISA, its regulations and federal common law.

56. As a result, Aetna failed to provide a "full and fair review" under ERISA, failed to provide reasonable claims procedures, and failed to make necessary disclosures to its Members and Plaintiff Restivo, pursuant to her assignment as a Nonpar provider.

57. By virtue, *inter alia*, of Aetna's numerous procedural and substantive violations, any appeals by Plaintiff Restivo and the Class relating to Aetna's revised benefit determinations as described herein should be deemed exhausted or excused under ERISA and its underlying regulation, as provided in 29 C.F.R. § 2560.503-1(l).

58. Plaintiff Restivo's failed appeals, as alleged hereinafter, further show the futility of exhausting appeals to Aetna. Exhaustion of internal appeals under ERISA should, therefore, be deemed to be futile.

59. Aside from its procedural infirmities, Aetna's revised benefit determinations as reported in its 8/8/07 Letter were invalid, arbitrary and capricious under ERISA, and should be

reversed, including its imposition of the unnecessary and burdensome requirement that Plaintiff Restivo be subjected to pre-authorizations in the future for numerous services. This is solely designed to intimidate Plaintiff Restivo and discourage her as a Nonpar provider from submitting further claims to Aetna, without any valid basis under its Plans, in violation of ERISA.

The 97140/CMT Issue

60. Aetna's interpretation of CPT Code 97140 is improper and inconsistent with generally accepted chiropractic standards of care. Plaintiff Restivo properly billed CPT 97140 for Myofascial Trigger Release treatments, applied to specific soft tissues to reduce adhesions and scar tissue in order to restore muscle function and flexibility. This treatment helps relieve the toxic waste build up in the muscle (such as lactic acids), which produces painful, sore and stiff joints. Through the treatments, chiropractic adjustment is enhanced through pain control, enhanced metabolic function, lymphatic drainage and regeneration of the injured intercostals, shoulder, arms, legs and other muscles. In Plaintiff Restivo's records relating to each of her patients for which she billed CPT 97140, she include a detailed diagram of the human body with markings in the areas in which myofascial release was performed on the patient. In making its revised claim denial, as reported in the 8/8/07 Letter, Aetna intentionally and willfully ignored such supporting documentation.

61. In contrast to manual therapy under CPT Code 97140, CMT is done to affect changes to the bony regions and joint articulations, and therefore has a distinctly different clinical purpose and intent. Plaintiff Restivo's billings for both CPT Code 97140 and CMT were entirely appropriate and consistent with generally accepted chiropractic standards. As such, she was not overpaid by Aetna for such services and should not be penalized by the imposition of inconvenient and time-consuming preauthorization requirements Aetna seeks to impose on her as

a Nonpar provider.

The Aqua Massage Issue

62. Aetna's assertions with regard to the Aqua Massage Issue in its 8/8/07 Letter are invalid and incorrect both with regard to the use of CPT Code 97022, Whirlpool, and to its determination that Aqua Massage is experimental and investigational. In fact, Plaintiff Restivo properly used CPT Code 97022 and Aqua Massage is a generally recognized chiropractic service that does not meet the definition of the experimental and investigational exclusion contained in Aetna's health care plans.

63. In response to the 8/8/07 letter, Plaintiff Restivo approached the ACOM Healthcare Business Consulting Group ("ACOM") to inquire as to what proper CPT Code to use for Aqua Massage (otherwise referred to as "dry hydro-therapy treatment"). Examining the CPT Codes that are potentially applicable to Aqua Massage, and the nature of the treatment itself, ACOM concluded: "[T]here is no question as to the proper code to bill for the dry hydro-therapy. You should bill the 97022; application of a modality, one or more areas; whirlpool."

64. There is also no basis for Aetna's conclusion that Aqua Massage (whatever the CPT Code) is experimental or investigational. The Aqua Massage device has been manufactured since 1990, and there are more than 2,900 systems installed in over 70 countries. The device itself holds a 510k premarket clearance from the Food and Drug Administration ("FDA"), authorizing its use for providing health care services since 1992. Further, not only is Aqua Massage a generally recognized service in the chiropractic community, but studies have shown its efficacy. For example, in a paper presented for peer review at the 18th Annual Scientific Meeting of the American Pain Society in October 1999, representatives from the Comprehensive Pain and Rehabilitation Center in Miami Beach, Florida reported on a scientific study that had

been conducted with respect to the use of Aqua Massage. The study concluded:

> On the average, patients reported a pain reduction of 1.4 (SD [Standard Deviation] = -1.8). Four patients (7.9%) reported pain elimination due to Aqua-Pt treatment. Additionally, 25 patients (20.3%) reported pain reduction of 50% or more. Overall, of the 123 patients, 65.6% reported pain reduction of various degrees; 29.6% reported no change in pain; and 4.8% reported pain increase. Increase in pain was, reportedly, due to being in the prone position for the treatment period.

65. A further study was conducted concerning the health care efficacy of Aqua Massage by Dr. Clarence Lloyd, based on an evaluation of 16 patients. He found that "[t]he level of pain was reduced from a mean of 5.25 to 2.5 according to VAS (Visual Analog Scale) in the patients with CPS" (Chronic Pain Syndrome).

66. A further study was also reported by AquaMED, a manufacturer of a leading hydrotherapy device, which reached similar conclusions:

> Stress exacerbates pain in patients suffering from Chronic Pain Syndrome (CPS). One adjunctive modality of pain management is dry thermal massage with AquaMED equipment. Thirty-two men and women, ages ranging from 18 to 80, were evaluated using AquaMED therapy to determine its effectiveness as a treatment modality in reducing stress. Subjects were divided into a healthy group and a pain group. Six cardiovascular indices were assessed as indicators of stress/ Systolic and diastolic blood pressure, heart rate, stroke volume, cardiac output, and oxygen saturation were evaluated before and at the end of the AquaMED therapy. Subjects reported subjective evaluations of perceived pain levels and perceived relaxation levels before and after therapy. CPS subjects showed a decrease in all indices except mean diastolic blood pressure. Overall, AquaMED therapy was shown to be an effective treatment modality for alleviating psychological stress and physical pain for promoting wellness.

67. Significantly, the State of Washington adopted regulations that specifically call for the Chiropractic Quality Assurance Commission ("CQAC") to "maintain a classified list of chiropractic procedures and instrumentation" that are deemed to be "approved" for treatments by chiropractors. Pursuant to this list, the CQAC has affirmative "approved" the use of aqua-med hydrotherapy tables, as well as intersegmental traction tables and SEMG (the latter two

treatments are discussed in greater detail below).

68. Based on these studies and the generally accepted use of Aqua Massage in the chiropractic community, Aetna's decision refusing to authorize benefits for this service was improper and in violation of ERISA.

Auto Traction Issue

69. When appropriate to do so, Plaintiff Restivo uses an Intersegmental Traction Table to provide services for her patients. Aetna was aware of Plaintiff Restivo's use of this device and has paid her it for lengthy periods of time, thereby waiving any argument now that it was not covered.

70. Treatments with an Intersegmental Traction Table are also generally accepted chiropractic services and cannot reasonably be denied based on the experimental and investigational exclusion. It is a service that is recognized directly in the CPT, which has code 97012, "Application for a modality to one or more areas, traction, mechanical." As explained by the American Chiropractic Association:

> According to CPT, mechanical traction is described as the force used to create a degree of tension of soft tissues and/or allow for separation between joint surfaces. The degree of traction is controlled through the amount of force (pounds) allowed, duration (time) and angle of pull (degree) using mechanical means. Terms often used in describing pelvic/cervical traction are intermittent or static (describing the length of time traction is applied), or autotraction (use of the body's own weight to create the force).
>
> A common question is whether roller table-type traction meets the above requirement. Roller table-type traction normally meets the requirements of autotraction, the use of the body's own weight to create the force.
>
> It is the position of the American Chiropractic Association that modalities such as mechanical traction are not included in the work of the CMT codes. Code 97012 should be used to describe these services, subject to documented medical necessity.

71. The use of an Intersegmental Traction Table as a "mechanical traction device" under CPT Code 97012 is particularly accepted as part of customary and chiropractic care. Indeed, 15 years ago this was acknowledged by the Eastern District of New York. In *Introna v. Allstate Ins. Co.*, 850 F. Supp. 161 (E.D.N.Y. 1993), a chiropractor brought an action against Allstate Insurance Company, seeking reimbursement for a variety of chiropractic services under New York State's No-Fault automobile insurance law. The issue was whether the services were deemed to be normal and customary services that would be subject to the No-Fault limitation on fees for chiropractic "treatment and modalities" or unusual procedures that could be entitled to separate payments. The court held:

> [T]he Court finds inescapable the conclusion that the bulk of the procedures for which the plaintiffs seek additional recovery are, as a matter of law, "normal and customary procedures and treatments offered by chiropractors and are, therefore, deemed included under the charges set forth in the Chiropractic Fee Schedule for Office Visits." *Tucciarone v. Progressive Ins. Co.*, No. 91-1981 (November 19, 1992, pp. 6-7 (Sup. Ct. Schenectady Co. 1992). The Court reaches this determination only after giving careful consideration to the evidence submitted by the parties and bearing in mind the purposes underlying the No-Fault Law and the clear language of the statute.
>
> For instances, the law is clear that fees for intersegmental traction treatments and spinal manipulation, two of the services at issue here, are included within the scheduled fee for office visits. *See Tucciarone, supra* at p.6. . . . The only reasonable inference that can be drawn from the evidence presented before the Court is that the services listed above lie squarely within the range of normal and customary "treatments and modalities" contemplated by the No-Fault fee schedule.

Id. at 165.

72. While the holding in *Introna* involved reimbursement under the No-Fault statute, an issue unrelated to plaintiffs' claims in this action, the *Introna* court affirmatively held that "intersegmental traction treatments," such as those provided by the Intersegmental Traction Table, "lie squarely within the range of normal and customary [chiropractic] 'treatments and

modalities' . . ." As a result, there is no basis for Aetna's decision not to cover such services.

The SEMG Issue

73. Aetna's conclusion that Plaintiff Restivo's billing for SEMG was improper as allegedly falling within the experimental and investigational exclusion clause of its health care plans is similarly unavailing. In truth, SEMG is a generally accepted chiropractic service for which Plaintiff Restivo is legally entitled to be reimbursed under ERISA.

74. The decision by Aetna to exclude benefits for SEMG came only after it had been paying such benefits for an extensive period of time. It therefore has waived any argument that such payment was improper.

75. SEMG procedures have been determined to be fully reimbursable as customary and accepted chiropractic services in multiple jurisdictions, including Washington, Wisconsin and Florida.

76. According to Washington State's CQAC, there are ten different reasons that could justify use of an SEMG. In order to be considered reasonable and necessary for purposes of being reimbursed for SEMG, a provider need only document three out of ten of the specified clinical reasons, including, but not limited to, a palpable paraspinal muscle spasm, a history of trauma to the spine and paraspinal muscle tenderness (pain on pressure). So long as three of the clinical reasons are specified, the provider may validly perform and be entitled to reimbursement for SEMG.

77. In a letter dated February 2, 2000, the Department of Regulation and Licensing for the State of Wisconsin similarly confirmed that SEMG is a generally accepted chiropractic procedure, finding that its use "is within the legitimate scope of practice for a chiropractor" if certain specified conditions are met.

78. In Florida, an Administrative Law Judge ("ALJ") specifically upheld the validity of SEMG services when the Department of Health sought to exclude coverage for such services as part of certain state regulations, stating:

> Overall, SEMG has advanced as a clinical took from its earliest, and more experimental uses. . . To today, when advances in technology and understanding have resulted in the elimination of problems of electrical interference, band width filtering and electrode placement, and have resulted in higher threshold of sensitivity.
>
> The evidence in this case demonstrates that SEMG has value for use in the treatment of persons sustaining bodily injury covered by personal injury protection benefits . . . it is clear that SEMG has a degree of demonstrated medical value. Therefore, its inclusion in the list of medically unnecessary tests is arbitrary and capricious; has exceeded the Department's grant of rule making authority; and has enlarged, modified or contravened the specific provisions of law implemented.
>
> The evidence also suggests that SEMG is generally accepted in the relevant provider community.

The ALJ then concluded that "SEMG has demonstrated medical value . . . [and] that SEMG has achieved a level of medical acceptance as a valuable diagnostic tool for injuries of the spine and upper and lower back."

79. The ALJ's decision was subsequently upheld by the Florida First District Court of Appeals. In its decision of January 5, 2006, the court held:

> [T]he final order clearly set forth the finding that surface EMG testing has significant medical value as a diagnostic tool with respect to the treatment of a patient suffering from injuries like those arising out of a motor vehicle accident. This finding is supported by competent substantial evidence and demonstrates that surface EMG diagnostic testing failed to satisfy the statutory requirement, even under the broader reading suggested by the Department, and thus should not have been included on the list [of services deemed not to be medically necessary].

Dep't of Health v. Merritt, Case No. 1D05-729 (1st DCA, Fla. Jan. 5, 2006), *slip op*. at 8.

80. Numerous studies have also been done that substantiate the medical benefits of

SEMG. As a result of the Washington State policy, the Florida court decision, and these studies, Aetna's strict policy excluding coverage for SEMG pursuant to the experimental and investigational exclusion is clearly invalid, arbitrary and capricious.

5 Region CMT Issue

81. Aetna arbitrarily downcoded Plaintiff Restivo's billing for CPT Code 98942, stating that for 69% of the time she should have coded 98941 for fewer regions for which she used CMT instead. Aetna had no basis for its decision to downcode Plaintiff Restivo's billing for these services. In reporting this conclusion in its 8/8/07 Letter, Aetna failed to provide any explanation for its determination, and it cannot apply an unrelated statistical analysis to exclude benefits for Plaintiff Restivo.

82. Plaintiff Restivo billed for CPT Code 98942 when she performed CMT on at least five regions. Therefore, she was entitled to receive benefits based on the services she provided and properly billed for, and Aetna's decision otherwise was improper, arbitrary and capricious.

Pre-Payment Review Issue

83. As its final conclusion, Aetna stated that it would now impose a requirement whereby each time Plaintiff Restivo submitted claims for CPT Codes 98942, 95999, 97022, 97140 or 97012 it would first review those claims prior to payment. There was no basis for this conclusion, as Plaintiff Restivo properly coded for each of her services. Such a requirement is not permitted under any of Aetna's health care plans and is therefore improper, arbitrary and capricious.

84. Aetna has subsequently imposed Pre-Payment Review on all of Plaintiff Restivo's claims, regardless of what CPT Code she bills. Aetna has used this practice as an excuse to deny virtually all of her claim submissions, such that – as a punitive measure – her patients are now

excluded from receiving insurance coverage for services she provides. These denials are without basis and, similarly, are in violation of ERISA and arbitrary and capricious.

85. By establishing burdensome and improper requirements on services provided by Nonpar providers, such as the pre-review requirement Aetna improperly imposed on Plaintiff Restivo, Aetna unlawfully discriminated against its members who use Nonpar services, and against their Nonpar providers, in violation of ERISA, section 510 (29 U.S.C. § 1140).

Plaintiff Restivo's Exhaustion of Administrative Remedies

86. In issuing its 8/8/07 Letter, Aetna was reporting on a revised benefit determination whereby it had elected – after the fact – to deny benefits that had previously been approved. Under ERISA, Aetna cannot legitimately require restitution for prior payments.

87. Further, to the extent Aetna made a new claim denial, it is obligated under ERISA to satisfy various regulatory requirements, including providing appropriate grievance procedures that are adequately disclosed. Because Aetna failed to comply with these requirements, any administrative remedies are deemed exhausted and Plaintiff Restivo is entitled to bring this action for relief.

88. Notwithstanding the fact that Aetna improperly failed to disclose any administrative remedies, Plaintiff Restivo made an exhaustive effort to appeal Aetna's decisions, but to no avail.

89. In response to Aetna's 8/8/07 Letter, in September 2007 and again in October 2007, Plaintiff Restivo requested the SPDs and the applicable Clinical Bulletins for each of the patients whose treatments were covered in Aetna's repayment demands. These requests were made to Aetna, which operated either as the designated or de facto plan administrator for the health care plans it insured and/or administered. Aetna refused these requests, instead only

providing an itemized list of patients by name and date of service. In doing so, Aetna violated its obligations under ERISA and is subject to statutory penalties under 29 U.S.C. §1132(c)(1).

90. By letter dated December 11, 2007, counsel for Plaintiff Restivo sent a detailed letter to Aetna to protest the conclusions in its 8/8/07 Letter and to seek reconsideration. In doing so, Aetna challenged each of its determinations raised herein, and attached substantial information in support of Plaintiff Restivo's position.

91. After Aetna failed to overturn its decisions, and continued to seek restitution for each of the payments identified in its 8/8/07 Letter, Plaintiff Restivo sent a follow-up letter to Aetna as the plan administrator under ERISA for certain of the patients whose treatments were covered in Aetna's repayment demand. In this letter dated July 18, 2008, Plaintiff Restivo reiterated her demand for the appropriate SPDs and also provided in substantial detail the basis for her challenge and why Aetna's benefit denials were improper.

92. On October 17, 2008, as part of her effort to challenge Aetna's improper recoupment demand, Plaintiff Restivo actually met with Aetna officials in New York City at Aetna offices to discuss her appeal. However, Aetna officials refused to discuss the appeal, but simply demanded payment and threatened to pursue litigation in which they would seek an even higher amount if she did not agree to pay.

93. Thereafter, Aetna continued to refuse to pay the benefits or to reconsider its decision in the 8/8/07 Letter. In fact, on December 18, 2008, outside counsel retained by Aetna, Stuart D. Markowitz, P.C., wrote Plaintiff Restivo's counsel threatening a lawsuit, stating:

> As you know, our firm represents Aetna for the purpose of pursuing recovery of overpayments made by Aetna to your client, Donna Restivo, DC.
>
> Since this matter has not been resolved amicably, my client has advised me to immediately proceed with litigation. Please advise as to whether you are

> authorized to accept service on behalf of Donna Restivo, PC. If I do not hear from you, then we will serve Dr. Restivo personally with a Summons and Complaint to recovery the overpayment amount of at least $50,650.22.

94. Aetna subsequently issued numerous final denials of individual appeals Plaintiff Restivo filed with regard to specific patients identified in the 8/8/07 Letter, stating that Plaintiff Restivo had not filed her appeals in a timely fashion. This conclusion was false and in violation of ERISA. Plaintiff Restivo had appealed each of the denials relating to the 8/8/07 Letter within the required time frames and, in any event, Aetna had failed to properly disclose of its appeal requirements at the time it announced its benefit determinations.

95. For the reasons detailed herein, Plaintiff Restivo fully exhausted all applicable administrative review procedures. If actual exhaustion is not found, such procedures should be deemed exhausted due to Aetna's violation of ERISA regulations as pursuing further appeals would be futile.

PLAINTIFF CARNUCCI'S EXPERIENCE WITH AETNA'S GROUP HEALTH PLANS

96. Dr. Carnucci, by and through his practice, Westfield Health and Wellness, LLC, submitted and still submits claims to Aetna as a Nonpar Provider and an assignee of certain Aetna Insureds since 2002. As a matter of office policy, Dr. Carnucci requires every Aetna Insured who seeks care in his office to: (1) provide a copy of their insurance card so that his office can verify what services provided by his office are "Covered Services" under the terms and conditions of the patient's Plans; and (2) sign a "Financial Policy" document whereby the patient assigns all insurance benefits to Dr. Carnucci's practice and agrees to pay Dr. Carnucci directly for those services and treatments deemed not to be "Covered Services" by Aetna.

97. Dr. Carnucci, by and through his practice, Westfield Health and Wellness, LLC,

provided and still provides chiropractic and physical therapy services to Aetna Insureds. After providing these services to Aetna Insureds, Dr. Carnucci submits a bill directly to Aetna, either electronically or via mail, on a HCFA/CMS 1500 form, which requires Dr. Carnucci to provide, among other things: (1) the name of the patient; (2) whether the patient executed a valid assignment of benefits; (3) certain codes that identify or describe the patient's underlying diagnoses ("ICD-9"); (4) certain codes that identify or describe the specific services rendered ("CPT"); and (5) the identity of the treating Provider.

98. Between September 2002 and March 2008, Aetna paid Dr. Carnucci, by and through his practice, Westfield Health and Wellness, LLC, $775,271.28.

99. In or about June 2005, Dr. Carnucci received a letter from John M. Kelly, Senior SIU Investigator in Aetna's SIU in Iselin, New Jersey. In that letter, Aetna announced that it was conducting a Post Payment Audit of claims submitted by Dr. Carnucci to Aetna Life Insurance Company or one of its affiliates and requested full and complete copies of the chiropractic treatment records corresponding to approximately ten (10) of Dr. Carnucci's patients who were Aetna Insureds, who agreed to such a review as part of Aetna's enrollment forms. By its use of this form, Aetna expressly conceded that its entitlement to the records arises out of the Plans through which Aetna offers, underwrites, or administers health benefits.

100. On or about September 26, 2006, Dr. Carnucci received a second letter from Aetna's SIU; this one from Phyllis Ortiz, a Senior Investigator located in Cranbury, New Jersey. In her letter, Ms. Ortiz indicates that Aetna's Post Payment Audit of Dr. Carnucci and his practice "identified a discrepancy between the billing and medical records." Specifically, Ms. Ortiz indicated that "[t]he discrepancy involves the use of CPT codes 97140 and 97530" and that CPT codes 97140 and 97530 "are not documented as having been performed," and thus are not

"Covered Services." Ms. Ortiz also readily admitted that while records were only reviewed for services provided through "mid 2005," Aetna's findings were based upon a review of "adjudicated dates 1/5/03 to 8/25/06." Ms. Ortiz's letter did not, however: (1) provide a specific amount Aetna claimed to have overpaid to Dr. Carnucci or his practice as a result of its Retroactive Benefit Determinations; (2) explain the specific bases for its Retroactive Benefit Determinations on a patient-by-patient, claim-by-claim basis; (3) offer to provide any of the Plan documents for the patients at issue, pursuant to which its Retroactive Benefit Determinations were based; or (4) articulate the manner in which Dr. Carnucci could request an appeal or some other "full and fair review" of Aetna's Retroactive Benefit Determinations. Instead, Ms. Ortiz merely offered Dr. Carnucci's counsel the "opportunity to discuss these findings, and reach an agreement concerning the overpayments to date." Notably, this letter itself was false and misleading as the records submitted by Dr. Carnucci clearly and unambiguously indicate the performance of services that are properly reported and paid under CPT codes 97140 and 97530.

101. On or about April 3, 2007, after repeated requests by Dr. Carnucci's counsel for additional information relative to Ms. Ortiz's letter dated seven months earlier, Aetna sent an email to Dr. Carnucci's counsel wherein it indicated that there was not "anything additional to discuss." Moreover, this email, written by Linda Delaney, a Manager in Aetna's SIU Office in Cranbury, New Jersey, stated that a recent "trend report," generated by a program co-developed by Aetna and IBM as described below, indicated that certain codes, including CPT 97140, were being reported far more often than in the past by Dr. Carnucci and his Practice. Ms. Delaney, however, made no mention of whether this "trend report" also indicated whether or not Dr. Carnucci was simply treating more Aetna Insureds than he had before or whether the "trend report" took into account an increase in treatments provided by the physical therapist employed

by Dr. Carnucci's practice, for whom CPT codes 97140 and 97530 would be regularly reported. Instead, Ms. Delaney communicated Aetna's desire to review an additional ten (10) patient records despite never having provided any specific findings with regard to the patient records already reviewed for services rendered between 2003 and 2004; findings that pursuant to Ms. Ortiz's prior correspondence were subject to Retroactive Benefit Determinations.

102. On or about August 6, 2007, Aetna, by and through counsel to its SIU, Barbara Tancredi, sent a letter to Dr. Carnucci's counsel restating its desire to review an additional ten (10) patient records despite still not having provided any specific findings about the first review.

103. On or about November 26, 2007, Ms. Ortiz sent a second letter; this time to Dr. Carnucci directly, despite his being represented by counsel. In her letter, Ms. Ortiz expressed Aetna's dissatisfaction with not having received the additional ten (10) patient records requested previously despite never having provided any specific findings with regard to the patient records already reviewed for services rendered between 2003 and 2004; findings that pursuant to Ms. Ortiz's prior correspondence were subject to Retroactive Benefit Determinations. To that end, Ms. Ortiz stated that all claims submitted to Aetna by Dr. Carnucci and his practice on behalf of Aetna Insureds would be subject to Pre-Payment Review. Ms. Ortiz described this process as merely requiring that all claims submitted by Dr. Carnucci would be "reviewed" by Aetna's "clinical staff" prior to payment. Ms. Ortiz further stated that if any claims were "paid in error for services that are not covered under Aetna plans, Aetna reserves the right to seek reimbursement from you for any additional overpayments." Notably, this letter itself was false and misleading in that is falsely portrayed the Pre-Payment Review process that, in practice and as applied specifically to Dr. Carnucci and his practice, is nothing more than an automatic "flag" placed in Aetna's claim processing software, which was co-developed with IBM, whereby each

and every claim submitted by the "flagged" Provider, in this case Dr. Carnucci and his practice, is denied for any number of reasons articulated by internal denial codes appearing on EOB statements mailed or forwarded electronically to both Dr. Carnucci and his patients. These denial codes are similarly false and misleading in that they intentionally misrepresent the true basis for the claim denials themselves.

104. On or about December 11, 2007, Dr. Carnucci, by and through his legal counsel, provided to Ms. Tancredi copies of the treatment records requested.

105. On or about August 25, 2008, Aetna, by and through counsel to its SIU, Ms. Tancredi, sent a letter to Dr. Carnucci's counsel alleging that "the review of patient records in connection with the submission of current claims has disclosed . . . [that] many of the treatment bills are not supported by the patient records," although she failed to provide any examples that would have given Dr. Carnucci an ability to challenge such misstatements. Ms. Tancredi further states that "Dr. Carnucci is billing for some services that are [not] covered by Aetna, such as decompression therapy." With regard to Dr. Carnucci's repeated inquiries as to Aetna's failure to process those claims subjected to Pre-Payment Review, despite his having provided treatment records on each, Ms. Tancredi indicated that Dr. Carnucci was "able to avail himself of the claim appeal process" and that "the SIU does not review Dr. Carnucci's current claims submissions and does not control the claim determinations." Finally, Ms. Tancredi's letter set forth "summaries" of "chiropractic findings" for the ten patients whose treatment records were provided to Aetna nine months prior. Notably, this letter itself was false and misleading in that: (1) the SIU does review current claim submissions as part and parcel of Pre-Payment Review; (2) the SIU does control claim determinations because the SIU unilaterally and without supervision controls the imposition of Pre-Payment Review, which by design triggers automatic claim denials; (3) Dr.

Carnucci, like any Provider subjected to Pre-Payment Review, was not able to avail himself of the appeal process because the claims were automatically denied without sufficient justification or explanation; (4) Aetna was not handling Dr. Carnucci's claims in the "ordinary course," as its "adjudicated codes" were those claims that were denied out-of-hand as part and parcel of Pre-Payment Review and these claims were never re-adjudicated upon Dr. Carnucci's providing copies of the corresponding treatment records for each and every claim submitted to Aetna as requested by Ms. Ortiz previously; (5) Dr. Carnucci's treatment records clearly and unambiguously indicate the need and performance of all services in issue; and (6) all services provided by Dr. Carnucci are "covered" as defined by the Plans in issue.

106. On or about September 3, 2008, Ms. Tancredi sent another correspondence to Dr. Carnucci's counsel whereby she stated that:

> As I indicated in my letter of August 25, 2008, Aetna's review of a sampling of Dr. Carnucci's patient records have disclosed many areas of concerns. As a result of these concerns, Aetna has calculated that as much as $597,643 has been overpaid to Dr. Carnucci for the period of from September 2002 through March of 2008. A CD containing a report of all claims included in the overpayment calculation is includes with this letter.

107. Ms. Tancredi then set forth that Aetna calculated the overpayment amount based upon the extrapolation of certain error rates claimed to have been identified in the samples of records reviewed to the entire universe of claims submitted by Dr. Carnucci and his practice between September 2002 and March 2008. These included services reported and paid under: (1) CPT 97140, Manual Therapy; (2) CPT 97110, Therapeutic Exercises; (3) CPT 97530, Therapeutic Activities; (4) CPT 98943, CMT, extraspinal; (5) CPT 97014, Electrical Stimulation, unattended; (6) CPT 98940, CMT, 1-2 regions; (7) CPT 97012, Mechanical Traction; (8) HCPCS G0283 Electrical Stimulation, unattended; (9) CPT 98942, CMT, 3-4

regions; (10) CPT 97010, Hot/Cold Packs; (11) CPT 97035, Ultrasound; (12) CPT 97112, Neuromuscular Reeducation; (13) CPT 95903, NCV Ea Motor w/ F-wave; (14) CPT 95904, NCV Ea Sensory; (15) HCPCS E0730, Transcutaneous electrical nerve stimulation ("TENS") device; (16) CPT 97001, PT Initial Evaluation; and (17) CPT 95934, H-Reflex R/L. In addition to the letter itself, Ms. Tancredi also sent a compact disc that contained a list of each and every claim reviewed relative to the "sample" of records provided by Dr. Carnucci previously. For each claim purportedly denied as a Retroactive Benefit Determination, the list set forth, among other things: (1) the patient (or Aetna Insured) on whose behalf the claim was submitted; (2) the date of service; (3) the primary diagnosis codes reported; (4) the CPT/HCPCS code reported as corresponding to the service in issue; (5) the Plan at issue, including the Plan sponsor; (6) and the "reason" why the claim was being denied as a Retroactive Benefit Determination reflected in a denial code. Neither Ms. Tancredi's letter itself, nor the compact disc enclosed therewith included any explanation of the denial codes represented. Notably, this letter and the enclosed compact disc were false and misleading in that: (1) the "extrapolation" was based on error rates that were entirely fabricated by Ms. Tancredi and the Aetna SIU; (2) the use of "extrapolation" is impermissible in the context of ERISA where Retroactive Benefit Denials must be particularized so as to permit a full and fair review of the adverse findings; and (3) the denial codes provided on the compact disc provided no cognizable basis for the adverse Retroactive Benefit Denials.

108. On or about June 16, 2009, in response to numerous inquiries from Dr. Carnucci's counsel as to the striking inconsistencies contained in prior "findings" as well as the refusal of Aetna to provide additional specificity with regard to its Retroactive Benefit Denials as well as an opportunity for Dr. Carnucci to appeal not only its overpayment demand, but also the ever-mounting backlog of claims denied as part and parcel of Pre-Payment Review, Ms. Tancredi sent

yet another letter to Dr. Carnucci's counsel. Ms. Tancredi stated that the denial codes contained on the compact disc provided previously were actually "payment codes," despite their being labeled as "denial codes." Moreover, instead of providing the specificity repeatedly demanded by Dr. Carnucci and his attorneys, Ms. Tancredi again simply "summarized" Aetna's so-called findings and restated the error rates that she and Aetna's SIU fabricated to justify an overpayment demand equal to approximately seventy-seven percent (77%) of all reimbursement paid to Dr. Carnucci and his practice between September 2002 and March 2008. Furthermore, Ms. Tancredi set forth additional "reasons" for Aetna's adverse Retroactive Benefit Denials. Specifically, she claims that Dr. Carnucci was "practicing outside the scope of a chiropractic's license" by performing certain "physical medicine codes" on dates of service "when no chiropractic manipulation was performed." Notably, this letter was false and misleading in that: (1) the denial codes provided on the compact disc sent to Dr. Carnucci on or about September 3, 2008, were, in fact, denial codes and not payment codes; (2) the "extrapolation" was based on error rates that were entirely fabricated by Ms. Tancredi and the Aetna SIU; (3) the use of "extrapolation" is impermissible in the context of ERISA where Retroactive Benefit Denials must be particularized so as to permit a full and fair review of the adverse findings; (4) the "physical medicine codes" were lawfully and appropriately performed by a licensed physical therapist employed by Dr. Carnucci and his practice, such that no chiropractic manipulation was required on the dates of service in question; (5) HCPCS E0730, or TENS, does not refer to an experimental or investigational service; and (6) the findings with regard to lacking or otherwise deficient patient records are also fabricated.

109. Aetna failed to comply with ERISA requirements in seeking to compel Dr. Carnucci to pay back proceeds he had previously been paid for providing services to Aetna

Insureds. Among other things, Aetna did not: (1) notify the affected Aetna Insureds that adverse Retroactive Benefit Denials had been made; (2) provide a sufficiently specific basis upon which its Retroactive Benefit Denials were being based to either the affected Aetna Insureds or to Dr. Carnucci; (3) provide a sufficiently specific basis upon which its Pre-Payment Review denials were being based to either the affected Aetna Insureds or to Dr. Carnucci; (4) make available SPDs or other explanatory Plan documents to either the affected Aetna Insureds or to Dr. Carnucci relative to either its Retroactive Benefit Denials or its Pre-Payment Review denials; and (5) offer an option to pursue an internal appeal or some other "full and fair review" of either those claims denied as part of the adverse Retroactive Benefit Denials or those claims denied as part of Pre-Payment Review.

110. In issuing both its adverse Retroactive Benefit Denials with regard to Dr. Carnucci's previously provided services to Aetna Insureds and its denials of claims subject to Pre-Payment review, Aetna did not offer the option for Dr. Carnucci to pursue any administrative remedies, in clear violation of ERISA. As a result, any such appeals should be deemed to have been exhausted under ERISA.

111. Dr. Carnucci did contest adverse Retroactive Benefit Denials with regard to his previously provided services to Aetna Insureds and its denials of claims subject to Pre-Payment review by seeking a reversal of these respective determinations. For example, for each and every claim denied as part and parcel of Pre-Payment Review, Dr. Carnucci provided copies of the corresponding treatment records to Aetna; nevertheless, Aetna failed to re-adjudicate these claims.

112. Any administrative remedies that may be required to be pursued under ERISA have been exhausted, should be deemed exhausted under applicable regulations, or would be

futile under the circumstances, and are therefore excused.

113. Aetna, by and through its Post Payment Audit, Retroactive Benefit Determinations, Recoupment Efforts, and Pre-Payment Review, as applied to Dr. Carnucci and his practice: (1) knowingly and willfully devised a scheme to defraud, or to obtain money or property by means of false pretenses, representations or promises; (2) knowingly transmitted or caused to be transmitted by wire in interstate commerce some sound for the purpose of executing the scheme to defraud; and (3) used the United States Postal Service by mailing, or by causing to be mailed, some matter or thing for the purpose of executing the scheme to defraud.

114. As a result of Aetna's improper and unlawful conduct, Dr. Carnucci sustained significant damages to both his personal and business property including, but not limited to: (1) all costs and time spent by Dr. Carnucci and his practice defending against Aetna's Retroactive Benefit Determinations and Recoupment Efforts; (2) all costs and time spent by Dr. Carnucci and his practice dealing with Aetna's Pre-Payment Review; (3) all reimbursement improperly denied to Dr. Carnucci and his practice related to Aetna's Pre-Payment Review of all claims submitted by his Practice to Aetna since November 2007, which, without interest as is required for claims paid in violation of New Jersey's prompt payment statute and regulations, and pursuant to ERISA, amounts to no less than one-hundred eighty-one thousand sixty-two dollars ($182,062.00).

PLAINTIFF FOGLIA'S EXPERIENCE WITH AETNA'S GROUP HEALTH PLANS

115. Over the years, Dr. Foglia provided numerous services on behalf of Aetna Insureds. His general practice before providing services is to verify with Aetna that the member is covered for generally accepted chiropractic services. After providing such services, he then

submits claims directly to Aetna on a HCFA 1500 form and, pursuant to assignments he receives from his patients, obtains payments from Aetna after determining that the services were "covered" under the patient's health care plan. Dr. Foglia's patients remain liable for any portion of the bill that is not covered by Aetna.

116. On November 6, 2007, Dr. Foglia received a letter from Aetna stating it was "conducting a retrospective review of services" for eight patients identified on an attached list, and requested copies of all relevant medical records going back to the beginning of 2004. In so doing, Aetna explained why it was entitled to such records, stating:

> Please be advised that as part of our benefit contracts and/or enrollment forms, our members and insureds authorize Aetna Life Insurance Companies or one of its affiliates (collectively "Aetna") to obtain medical records as a condition of coverage. We are permitted to obtain these records without obtaining an additional authorization from the member/insured, because we are both "covered entities" as defined by HIPAA. Specifically, 45 CFR 164.502(a)(1) allows such disclosures for "treatment, payment or health care operations."

117. As indicated in the letter, Aetna concedes that its entitlement to the records arises out of the health care plans through which the Aetna Insureds are insured.

118. Dr. Foglia prepared the records to send to Aetna but requested that it pay his copying costs of $305.50. Aetna, however, refused to do so, stating by letter dated December 5, 2007, that Aetna does "not pre-pay for any service, including a copy fee for records," but would allow for an after-the-fact payment of "$1.00 per page inclusive of research, copying and postage."

119. On April 14, 2008 ("4/14/08 Letter"), Dr. Foglia received a letter from Janine Carey, an Investigator with Aetna's Special Investigations Unit based in Cranbury, New Jersey. In the letter, Aetna represented that it had "completed a review of claims submitted by your office to Aetna Life Insurance Company or one of its affiliates (collectively 'Aetna') . . . for

claims processed April 8, 2006 through March 12, 2008," and had "identified an overpayment in the amount of $15,609.88."

120. Aetna stated in the letter that it had identified two bases for its repayment demand. First, it stated:

> During the course of our review, we found that you primarily submit claims for CPT code 98942. In all files reviewed, you billed a 5 region Chiropractic Manipulative Treatment (CPT code 98942); however the documentation in the records indicates that a 1-2 region CMT (CPT code 98940) was in fact performed. We allowed a benefit for CPT code 98940 in all instances when CPT code 98942 was billed and calculated an overpayment in the amount of $11,781.08.

121. As made clear in the letter, Aetna demanded a repayment for *all* services for which Dr. Foglia had billed CPT code 98942, even though Aetna had not sought documentation for or completed an analysis of all such procedures. This, by itself, is improper, as Aetna did not have a basis for concluding that Dr. Foglia had *never* performed a five region CMT, even assuming *arguendo* that there were issues for the eight patients whose records were examined. More importantly, the letter itself was false and misleading as the records submitted by Dr. Foglia clearly supported a 5-region CMT, which he later demonstrated to Aetna, as detailed below.

122. The 4/14/08 Letter further add a second basis for recoupment, stating:

> Secondly, we are concerned with your billings of CPT code 97012. Based on the patient files reviewed, it was noted Non-Invasive Vertebral Axial Decompression Therapy, or Vax-D Therapy, was administered when billing under CPT code 97012. Aetna has a published policy of not allowing payment for VAX-D Therapy (see www.Aetna.com Clinical Policy Bulletins - # 180; Vertebral Axial Decompression Therapy). Aetna considers vertebral axial decompression (e.g., buy means of the VAX-D Table, DRX9000, the DRS System, or the Internal Disc Decompression (IDD) Therapy) experimental and investigational. Currently, there is no adequate scientific evidence that proves the vertebral axial decompression is an effective adjunct to conservative therapy for back pain. In addition, vertebral axial decompression devices have not been adequately studied as alternatives to back surgery. Therefore, we consider the entire amount released

> for CPT code 97012 overpaid for the timeframe noted above and are seeking restitution in the amount of $3,828.80.

123. In its demand letter, Aetna did not offer to provide any of the plan documents for the patients at issue, pursuant to which its adverse benefit determinations were based, nor did it offer any appeal of its decisions. Rather, it simply asked Dr. Foglia to "send a check or money order in the amount of $15,609.88 for the overpayment indicated," payable to Aetna Life Insurance Company.

124. Aetna further put pressure on Dr. Foglia to make payment by stating that, as of May 8, 2008, it would require *all* claims he submitted under CPT code 97012 to "be reviewed prior to payment," adding:

> Records will be requested by the office where the claim is being processed and will be reviewed by the designated medical staff in that office. Should any of your claims be paid in error for services that are not covered under Aetna plans, Aetna reserves the right to seek reimbursement from you for any additional overpayments.

125. Finally, Aetna gave Dr. Foglia only two weeks "to discuss these findings and to reach an agreement concerning the overpayments made to-date," stating that "[i]f we do not hear from you by May 23, 2008, we will assume you are not interested in resolving this matter and we will proceed accordingly." Thus, Aetna did not offer any means by which Dr. Foglia could appeal or seek reconsideration of its recoupment demand.

126. In response to the 8/14/08 Letter, Dr. Foglia responded immediately, initially informing Aetna that it was incorrect in its assertions that his records did not support the billing of CPT code 98942 for a 5-region CMT. After various telephone calls with Aetna personnel, Dr. Foglia was able to demonstrate to them that his records did, indeed, fully support his billing of 98942, based on his use of a 5-region CMT. There was no basis in Aetna's contrary conclusion

stated in the 8/24/08 Letter. Aetna subsequently withdrew its demand for restitution based on that code. This is the only example where Aetna had been compelled to withdraw or alter its recoupment demand based on a provider's objection. Even here, however, it did not drop its demand, but merely reduced it.

127. Aetna continued to press for payment based on Dr. Foglia's billing for Vax-D Therapy, using the DRX9000 Non-Surgical Spinal Decompression System. While Aetna has adopted CPB 0180, which states that vertebral axial decompression (through a Vax-D table such as the DRX9000) is deemed to be experimental and investigational, Dr. Foglia – as a Nonpar provider – is not required to comply with Aetna's internal policies. Thus, the only basis upon which Aetna could deny coverage would be if it deemed the services not be covered under the terms of its health care plans, thereby requiring compliance with ERISA.

128. Aetna failed to comply with ERISA requirements in seeking to compel Dr. Foglia to pay back proceeds he had previously been paid for providing services to Aetna Insureds. Among other things, it did not notify the Aetna Insureds that an adverse benefit determination had been issued, it did not make available SPDs or other plan documents to the Aetna Insureds or Dr. Foglia, and it did not offer an option to pursue an internal appeal.

129. Aetna threatened Dr. Foglia if he did not agree to settle by stating that it would place his office under a special Pre-Payment Review requirement whereby it would require individualized review of all medical records of all of his patients before paying any benefits. Because Dr. Foglia recognized that this practice could cause undue strain and injury on his practice, he agreed – under coercion – to pay Aetna $1,915 (or half of the claimed overpayment for his use of CPT code 97012) to resolve the demand relating to his billing CPT code 97012.

130. While Dr. Foglia paid Aetna to resolve the dispute, he did not pay willingly, but

only because of the improper threats made by Aetna. The settlement between Dr. Foglia and Aetna was reached only as a result of Aetna's improper actions, taken in violation of ERISA, and should therefore be rescinded, with the payment returned.

131. Aetna's conclusion that the use of the DRX9000 was experimental and investigational is also incorrect and without valid basis. This equipment has been cleared by the Food and Drug Administration ("FDA") for providing mechanical traction and, further, numerous studies support its efficacy and safety. Moreover, the American Chiropractic Association, after evaluating the meaning and purpose of mechanical traction, has specifically concluded that "code 97012 would be an appropriate code to report for various types of mechanical traction devices (e.g,, computerized/motorized) *including vertebral axial decompression*." (Emphasis added.)

132. As a result, even assuming the validity of Aetna's practice of making an after-the-fact benefit determination, it wrongly concluded that the services at issue were not covered. Instead, Aetna validly paid them previously, and should continue to do so, as they represent generally accepted health care services in the chiropractic community.

Plaintiff Foglia's Exhaustion of Administrative Remedies

133. In issuing its adverse benefit determinations with regard to Dr. Foglia's previously provided services to Aetna Insureds, Aetna did not offer the option for Dr. Foglia to pursue any administrative remedies, in clear violation of ERISA. As a result, any such appeals should be deemed exhausted under ERISA.

134. Dr. Foglia did contest Aetna's adverse benefit determinations and sought a reversal of its decision. He succeeded with respect to Aetna's improper demand relating to CPT code 98942, and was coerced into settling with regard to CPT code 97012.

135. Any administrative remedies that may be required to be pursued under ERISA have been exhausted, should be deemed exhausted under applicable regulations, or would be futile under the circumstances, and are therefore excused.

THE EXPERIENCE OF PLAINIFF MANZ
WITH AETNA'S GROUP HEALTH PLANS

136. Since at least 2000, Dr. Manz, as the owner and clinic director of Midwest Chiropractic Center, has been a Par provider for Aetna and has provided medically necessary chiropractic health care services to numerous Aetna patients. Pursuant to assignments he received from his patients, he submitted claims directly to Aetna and he was paid amounts consistent with his provider contract for Covered Services under his patients' Aetna health care policies. Until the beginning of 2008, Aetna never had a problem with any of Dr. Manz's billings or practices.

137. The first time Aetna raised any questions about Dr. Manz's services was in early 2004. On May 18, 2004, Mr. Kelly, from Aetna's SIU office in New Jersey, wrote Dr. Manz to request medical records for 14 patients, staing that Aetna was "conducting a review of claims for services rendered to [those] patients." As part of the letter, Mr. Kelly included a questionnaire, which asked for the following information:

1. Please list the name, manufacturer, and model number of any devices you us, if any, for what your office submits claims for CPT code 97012 Mechanical Traction.
2. Please list the name, manufacturer, and model number of any devices you use, if any, for which yoru office submits claims for CPT code 97110 Therapeutic Procedures.

In a telephone conversation on May 26, 2004, Mr. Kelly informed Dr. Manz's office that he only needed the records from 2000 to the present.

138. Shortly thereafter, Dr. Manz submitted the records and responded to the questionnaire. Among other things, Dr. Manz informed Aetna that he used the ATT 300 Intersegmental Traction Table and a posture pump, Model 1000, for which he billed 97012 for mechanical traction, and that he used the Hill Laboratories Air Flex table among other treatments for which he billed 97110 for therapeutic procedures. Thereafter, Aetna took no further steps in response to that information and continued to pay Dr. Manz for his claims, including when he billed 97012, using the intersegmental traction table.

139. By letter dated January 17, 2008, almost four years later, Aetna wrote Dr. Manz agaom to inform him that it was "conducting a retrospective review of services rendered" with respect to 10 of his patients, for services performed since 2006. Aetna requested records from Dr. Manz for those patients, and also submitted a similar questionnaire to what had been sent in 2004 concerning the types of equipment he used in is office. Dr. Manz again provided the requested information, on February 25, 2008, informing Aetna that he had in his office three different devices for providing mechanical traction, including the the ATT-300 Intersegmental Traction Table, the posture pump, and the Hill Table. He later supplemented his submission by reporting that he had weighted bags and pulley systems in the office as well.

140. Dr. Manz did not hear anything further from Aetna until he received a letter dated August 25, 2008 from Janice Carey, an Investigator in Aetna's Special Investigations Unit, based in Princeton, New Jersey ("8/25/08 Letter"). In the letter, Aetna stated that it had "completed a review of claims submitted by your office to Aetna Life Insurance Company or one of its affiliates (collectively 'Aetna') . . . for claims processed July 31, 2006 thr[ough] July 31, 2008," and had "identified an overpayment to you in the amount of $20,290.09."

141. The recoupment demand was based on the use of two billing codes, CPT Code 97110 (Therapeutic Exercises) and CPT Code 97102 (Mechanical Traction). With regard to 97110, Aetna stated:

> Our Chiropractic consultant found that the documentation in the records failed to specify techniques employed, the parameters utilized and the body region addressed when billing this procedure. In addition, as this is a time sensitive code, it would be prudent to document the time spent at each encounter. Aetna considers Cpt code 97110 to be overpaid in the amount of $10,829.29. This figure represents 100% of the total amount released for CPT code 97110 for the time period noted above for all patients for whom you billed this code, not just the files that we reviewed.

142. The allegations asserted by Aetna in its 8/25/08 Letter are patently false, as Dr. Manz's records properly "specify [the] techniques employed, the parameters utilized and the body region addressed when billing" CPT Code 97110. Yet, Aetna gave no opportunity for Dr. Manz to discuss his records with Aetna's "Chiropractic consultant" or otherwise to provide additional evidence to support the fact that he had provided the relevant services. Further, Aetna not only sought recoupment for the 10 patients whose records it had reviewed, but it also sought full recoupment for *all* patients for whom Dr. Manz had provide services and billed CPT Code 97110, even though Aetna had not asked for or reviewed the documentation for the others. Notably, Aetna did not even make clear how many of the records it reviewed included billing for CPT Code 97110 as opposed to CPT Code 97012, or other procedures. Making such a recoupment demand based on extrapolations from a limited review of records is patently improper under ERISA and common law.

143. With regard to 97012, Aetna stated:

> In reviewing the patient records, our chiropractic consultant indicated that either this procedure was not documented or Intersegmental Traction was performed. Aetna has long had a published public policy of not allowing payment for the use of certain types of Mechanical Traction equipment (see www.Aetna.com Clinical

> Policy Bulletins – 569 Lumbar Traction Devices). Aetna considers the use of the Intersegmental Traction Table experimental and investigational because of lack of evidence of its efficacy, particularly in comparison with other forms of traction. Because the clinical evidence is limited and conflicting, no conclusion can be drawn about the efficacy of Auto Traction, or about its effectiveness in comparison with other forms of traction. Therefore, Aetna considers the amount of $9,460.80 to be overpaid. This figure represents 100% of the amount you have inappropriately reimbursed for CPT code 97012 for the time frame noted above for all patients for whom you billed this code, not just the files we reviewed.

144. As detailed above, Aetna was demanding in 2008 the repayment of benefits that Dr. Manz had received for billing 97012 for the Intersegmental Traction Table even though Aetna had known of Dr. Manz's use of that device since at least 2004. Aetna gave no explanation for why in 2004 it elected not to raise further issues with regard to Dr. Manz's use of that device, and to continue to pay him, only to reverse its position and demand repayment some four years later.

145. Further, as explained above, Aetna's determination that the use of an Intersegmental Traction Table is not a covered service because it is investigational and experimental is invalid and without support. To the contrary, the evidence clearly demonstrates that an Intersegmental Traction Table is generally accepted within the chiropractic community and clearly falls within covered services of Aetna's health care plans. As such, Aetna's determination to the contrary is invalid, and arbitrary and capricious.

146. In its 8/25/08 Letter, Aetna gave no opportunity for Dr. Manz to object to or appeal its determination. Instead, it simply stated: "Please send a check or money order in the amount of $20,290.09 for the overpayment indicated. Make your check payable to Aetna Life Insurance Company and mail to the following address." The address was then specified as being to Lyn Delaney, a Senior Investigator in Aetna's SIU, based in Princeton, New Jersey.

147. To pressure Dr. Manz into settling with Aetna, it also specified that it was placing

him in Pre-Payment Review, stating:

> As of September 1, 2008, Aetna will require that all claims you submit for reimbursement under CPT code 97012 be reviewed prior to payment. Records will be requested by the office where the claim is being processed and will be reviewed by the designated medical staff in that office. Should any of your claims be paid in error for services that are not covered under Aetna plans, Aetna reserves the right to seek reimbursement from you for additional overpayments.
>
> We are offering you the opportunity to discuss these findings and to reach agreement concerning the overpayments made to-date. If we do not hear from you by September 18, 2008 we will assume you are not interested in resolving this matter and we will proceed accordingly.

148. Aetna's warning that it reserved the right to seek further recoupments to the extent it was determined that any of Dr. Manz's claims had been paid in error for services "that were not covered under Aetna's plans" conclusively establishing the connection between Aetna's health care plans and any obligation to repay benefits by Dr. Manz.

149. From the 8/25/08 Letter, it was clear that Aetna was not offering any appeal process to Dr. Manz, but was simply notifying him of its recoupment demand and offering him an opportunity to negotiate on the amount, with the Pre-Payment Review going forward serving as a hammer to force his hand. Aetna thereby violated its explicit obligations under ERISA.

Plaintiff Manz's Exhaustion of Administrative Remedies

150. Following receipt of the 8/25/08 Letter, Dr. Manz retained counsel to pursue an appeal of Aetna's adverse benefit determination, notwithstanding that Aetna was not offering such an appeal process. By letter dated September 30, 2008, Dr. Manz's counsel objected to Aetna's demand and asserted that it had no basis. First, with regard to CPT Code 97710, the appeal letter asserted that Dr. Manz's patient records properly recorded the necessary information, and had apparently been misread by Aetna's reviewer. The letter further stated:

> If there is a specific record examined by your reviewer that was incomplete, we

> would be happy to address that specific instance. In general, however, the records meet all of the objections raised in your letter. Accordingly, Dr. Manz was not overpaid on this CPT Code.

151. With regard to CPT Code 97012, the letter objected to Aetna's conclusion that an intersegmental traction table does not provide "mechanical traction," and further stated that this was only one type of service used by Dr. Manz to provide mechanical traction. Rather, the letter pointed out that Dr. Manz billed for mechanical traction on a number of occasions when, as is reflected in the notes, he used other devices, such as a Hill Table, which were not challenged by Aetna. As a result, Aetna's conclusion that it had improperly paid each and every time CPT Code 97012 was used was patently incorrect even under its own flawed policies. The letter then offered to go over specific issues with Aetna, stating:

> Again, if there is a specific record examined by your reviewer that was incorrectly billed to Aetna, we would be happy to address that specific instance. In general, however, the records meet all of the objections raised in your letter. Accordingly, Dr. Manz was not overpaid on this CPT Code.

152. Aetna responded to Dr. Manz's appeal letter on October 21, 2008. Rather than taking up Dr. Manz's suggestion that specific problems with particular billings be discussed, Aetna merely reiterated its across-the-board demand for repayment on *all* services for which Dr. Manz had billed CPT Code 97110 or 97012, despite the fact that Aetna had not even examined the medical records for the vast percentage of patients. Aetna also attached a copy of its Clinical Policy Bulletin ("CPB") No. 0569, which purportedly showed the basis for its rejection of the intersegmental table as mechanical traction.

153. While rejecting any appeal by Dr. Manz outright, Aetna limited its response to negotiating how much Dr. Manz would pay, again using the threat of litigation as a bargaining chip, stating:

> We are sincerely interested in resolving this matter without litigation. As such, we are willing to settle this matter at this time, for reimbursement of all claims submitted by your client using CPT codes 97110 and 97012 in the amount of $15,000.00 This proposal, of course, is an offer of compromise and is made without prejudice to the rights of the parties and will remain open until November 13, 2008. Aetna expressly reserves the right to withdraw, modify or revoke this offer at any time prior to acceptance.

154. By letter dated November 4, 2008, Dr. Manz's counsel responded to Aetna's October 21, 2008 letter. With regard to CPB 569, the letter noted that "the research cited as background for the policy indicates that autotraction is at least as effective, and perhaps greatly more effective, than other forms of traction."

155. In particular, in its CPB 569, Aetna cited what it claimed were the "only two published randomized clinical studies comparing autotraction to other forms of traction," claiming the results "are conflicting." The first study "compare[ed] conventional passive traction to autotraction" and concluded that "[t]he favorable response to autotraction was 75% (30 of the 40 patients) versus the 22% (6 of 27 patients) to conventional passive traction." The second study purportedly "found no differences in effectiveness between autotraction and manual traction." After evaluating 49 patients, with a "blind overall assessment" over a three month period, the study "showed that the two traction modalities are equally efficient."

156. Aetna did not take into account many valid tests and other evidence that confirm the efficacy of autotraction, in reaching its conclusion that it is experimental and investigational. Moreover, even considering the "only two randomized clinical studies comparing autotraction to other forms of traction," Aetna itself recognized that one study found autotraction to be materially *more* effective than manual traction, while the other study found the approaches to be "equally efficient." Thus, far from showing a lack of efficacy for autotraction, both studies showed that it was effective. Significantly, since Aetna pays a set rate to Dr. Manz when he bills

for CPT Code 97012, whether he the Intersegmental Traction Table or other device, it should make no difference to Aetna which method is used, since they are, at least, "equally" effective. Aetna's denial of coverage based on the experimental and investigational exclusions in its health care plans are without a reasonable basis, and are arbitrary and capricious.

157. In Dr. Manz's November 4, 2008 letter, his counsel also questioned the legitimacy of Aetna seeking recoupment for each and every billing of CPT Code 97012, when it had not considered the fact that, for at least some of these billings, Dr. Manz had used other forms of traction that are indisputably covered by Aetna. The letter further reiterated Dr. Manz's challenge to Aetna's conclusions with regard to his documentation for CPT Code 97110, again offering to go over specific questions with particular billings with regard to any concerns Aetna might have, stating:

> With respect to CPT code 97110, we respectfully disagree with your reviewer and are uncertain as to how anyone reviewing Dr. Manz records could fail to find the body regions addressed, the techniques utilized or the time spent. Again, if there are specific claims in which the documentation was somehow not complete, we are happy to review them. However, since you have provided us only with generalities, we can only respond with them.
>
> Again, we are happy to review any specific claims as to whether errors were made in submitting them to Aetna. However, the general statements made are unsupportable, and therefore, Dr. Manz maintains that he has not been overpaid on any claims to the best of his knowledge.

158. Aetna failed to respond to Dr. Manz's last letter. Its failure to accept Dr. Manz's offer to go over specific documentation highlights the inherent problem with Aetna's practice of demanding recoupment based on extrapolations, without offering any appeal process. Under ERISA, Dr. Manz is entitled to appeal any adverse benefit determination whereby he could demand specific evidence concerning the purported inadequacies of his billing practices, something that Aetna has refused to provide.

159. Significantly, Aetna also violated Ohio law with regard to recoupment, assuming ERISA did not preclude Aetna's effort altogether. Under Ohio Rev. Code 3901.388(b), any recoupment effort is subject to the following limitations:

> A third-party payer may recover the amount of any part of a payment that the third-party payer determines to be an overpayment if the recovery process is initiated not later than two years after the payment was made to the provider. The third-party payer shall inform the provider of its determination of overpayment by providing notice in according with division (C) of this section. The third-party payer shall give the provider an opportunity to appeal the determination. If the provider fails to respond to the notice sooner than thirty days after the notice is made, elects not to appeal the determination, or appeals the determination but the appeal is not upheld, the third-party payer may initiate recovery of the overpayment.

160. In this case, Aetna utterly failed to provide an appeal process, or to consider Dr. Manz's appeal, such that its Recoupment Effort is invalid under Ohio law.

161. In the face of Dr. Manz's refusal to give in to Aetna's extortionate recoupment demand, Aetna elected to punish him by an ongoing practice of imposing Pre-Payment Review of literally all of his claims for Aetna Insureds, followed by nearly universal denials or such extensive delays in decisions as to have the identical effect.

162. While Aetna's 8/25/08 Letter had stated that it would require Pre-Payment Review for "all claims you submit for reimbursement under CPT code 97012," in fact it imposed that requirement for all Aetna patients and for all services. For example, by letter dated January 12, 2009, Aetna sent Dr. Manz a letter stated: "We are conducting a review of services rendered to the above named patient(s). We are writing to request the medical records for the time period indicated." The letter further confirmed the relationship between the "request" and Aetna's health care plans, by stating:

> Please be advised that as part of our benefit contracts and/or enrollment forms, our members and insureds authorize Aetna Life Insurance or one of its affiliates

> (collectively "Aetna") to obtain medical records as a condition of coverage. This patient was a member/insured of an Aetna affiliate during the dates of service above. We are permitted to obtain these records without obtaining an additional authorization from the member/insured, because you and we are "covered entities" as defined under HIPPA. Specifically, 45 CFR 164.502(a)(1) allows such disclosures for "treatment, payment or health care operations.

163. In the letter, Aetna asked for the information within 45 days, stating that it would make its "benefit determination" – further highlighting that this is all part of an ERISA determination – "either (1) within 15 days after we receive the information we need, or (2) within 45 days from the date you receive this letter, whichever is earlier." However, while Dr. Manz met the demand requirement by submitting the medical records on January 21, 2009, well before the expiration of the 45-day deadline, Aetna has yet to pay the benefits or to explain the basis for any denial.

164. Aetna sent the same letter for each Aetna Insured for whom Dr. Manz has submitted a claim. After Dr. Manz has submitted the requested medical records, the claim went into limbo, with the result being that Dr. Manz is effectively no longer being paid by Aetna for providing services to Aetna Insureds. This is in direct violation of ERISA requirements.

165. In light of the extensive effort by Dr. Manz to appeal Aetna's recoupment demand, notwithstanding its failure to offer such an appeal, and given Aetna's rejection of any effort to seek reconsideration of its demand, it is clear that Dr. Manz has exhausted any available administrative remedy and is entitled to bring this action under ERISA. Alternatively, the circumstances demonstrate that any further appeal would be futile or that the Court should find there to be "deemed exhaustion" due to Aetna's repeated violations of ERISA regulations.

THE EXPERIENCE OF PLAINTIFF EGOZI AND HIS AGENT AIH WITH AETNA'S GROUP HEALTH PLANS

166. For many years, Dr. Egozi performed his sophisticated ETS-C operative technique

to patients, successfully treating their severe and debilitating cases of hyperhidrosis. Many of his patients were insured by Aetna, and prior to mid-2007, Aetna deemed his surgery to be a covered service under the terms and conditions of its health care plans, and it had reimbursed him based on the applicable fee schedule under his Par provider contract.

167. Aetna knowingly provided coverage for Dr. Egozi's surgeries. On many occasions, Aetna initially denied the charges, often seeking further information. In those situations, Dr. Egozi pursued internal appeals on behalf of his patients and submitted further documentation relating to the procedures. In virtually all such situations, Aetna determined – after its Medical Directors had carefully examined the information submitted by Dr. Egozi – that the ETS-C operative procedure was, indeed, a covered service under Aetna's health care plans. At no time did Aetna ever suggest after completion of its review of Dr. Egozi's work that his provision of the ETS-C services was not appropriate or that it was in any way in violation of Aetna's policies or procedures.

168. On November 27, 2007 ("11/27/07 Letter"), Aetna wrote Dr. Egozi, seeking recoupment for almost $300,000 relating to prior payments for ETS-C surgeries performed on Aetna patients. While the letter referred to prior correspondence relating to the issue, this is the first communication of which Dr. Egozi is aware in which Aetna claimed that he had been improperly reimbursed for his services.

169. Despite the fact that Aetna had deemed all of his prior surgeries as covered services under its health care plans, Aetna now determined – after the fact – that Dr. Egozi's surgeries were not covered services, purportedly because Dr. Egozi had failed to comply with Aetna's internal policies as detailed in its CPBs. Aetna gave no explanation as to why it had previously authorized and paid for Dr. Egozi's services -- even after having conducting

exhaustive reviews of Dr. Egozi's medical records as part of internal appeals -- if he were, in fact, in violation of Aetna policies.

170. According to CPB 0310, titled "Thoracoscopic Sympathectomy" (another name for ETS), Aetna considered ETS medically necessary for "intractable, disabling primary hyperhidrosis (excessive sweating)" when the following conditions were satisfied:

- Topical aluminum chloride or other extra-strength antiperspirants are ineffective or result in a severe rash; and
- Unresponsive or unable to tolerate pharmacotherapy prescribed for excessive sweating (e.g., anti-cholinergics, beta-blockers, benzodiazepines) if sweating is episodic; and
- Iontophoresis or electrophoresis (e.g., Drionic® device) is ineffective (see CPB 229 – Iontophoresis); and
- Significant disruption of professional and/or social life has occurred because of excessive sweating.

171. Prior to providing the ETS-C operative procedure to any Aetna patients, Dr. Egozi first verifies that each of his patients have tried topical extra-strength antiperspirants, but without success, and that the patient's hyperhidrosis caused a significant disruption of his or her professional and/or social life. These conditions have therefore been satisfied.

172. Many of Dr. Egozi's patients also tried prescribed pharmacotherapy, but they were unresponsive or were unable to tolerate it. More importantly, this condition contained in CPB 0310 is inapplicable to Dr. Egozi's patients because it only applies "if sweating is episodic" and Dr. Egozi only performs his ETS-C operative procedure when such sweating is consistent and persistent, not merely episodic.

173. Finally, the use of iontopheresis or electrophoresis on Dr. Egozi's patients is also not required under Aetna's policies, pursuant to CPB 0229. CPB 0229 provides that iontophoresis will be deemed to be medically necessary for "intractable, disabling primary hyperhidrosis." However, in describing the potential use of iontopheresis, Aetna further provides

in CPB 0229 as follows:

> Iontophoresis is the introduction of ionizable drugs through intact skin by the administration of continuous, direct electrical current into the tissues of the body.
> . . . .
> Iontophoresis can be tried for intractable disabling primary hyperhidrosis when antiperspirants or pharmacotherapy are not effective (see CPB 504 – Hyperhidrosis (Hyperhidrosis)). Iontophoresis has been reported ***to provide temporary relief in mild cases of primary hyperhidrosis*** of the hands and feet. The procedure has to be repeated regularly, initially in 20-minute sessions several times a week, gradually stretching out the interval between treatments to 1-2 weeks; however, treatments must be maintained indefinitely ***to control the symptoms of mild hyperhidrosis***. The results vary: many find the electric current uncomfortable, the treatment expensive, time consuming, and the results not lasting long enough. The Drionic® device (General Medical Co., Los Angeles, California) is an iontophoretic device that can be purchased for home use. (Emphasis added)

As reflected in Aetna's own internal policies, Iontophoresis is only useful for purposes of providing "temporary relief" of "mild cases" of hyperhidrosis. Since ***all*** of the patients treated by Dr. Egozi with the ETS-C are first diagnosed with constant and severe cases of hyperhidrosis, Aetna's policy concerning the application of Iontophoresis is inapplicable.

174. This conclusion is further reinforced by CPB 0504: Hyperhidrosis. In discussing the potential treatment for hyperhidrosis, including through the use of ETS, Aetna states as follows in CPB 504:

> The simplest method to control or reduce profuse sweating is the application of topical agents, such as aluminum chloride or other extra-strength chemical antiperspirants. Usually recommended as the first therapeutic measure, ***topical antiperspirants are effective in cases with light to moderate hyperhidrosis*** but have to be repeated regularly.
>
> ***Oral prescription medications may be prescribed for situational or episodic hyperhidrosis*** . . .
>
> Iontophoresis or electrophoresis can be tried if antiperspirants are not effective. Iontophoresis uses electric current to enhance drug penetration through the stratum corneum, the principle barrier to percutaneous absorption. ***Iontophoresis has been reported to provide temporary relief in mild cases of primary***

> ***hyperhidrosis*** of the hands and feet. The procedure has to be repeated regularly, initially in 20-minute sessions several times a week, gradually stretching out the interval between treatments to 1-2 weeks; however, treatments must be maintained indefinitely to control the symptoms of mild hyperhidrosis. The results vary: many find the electric current uncomfortable, the treatment expensive, time consuming, and the results not lasting long enough. The Drionic device (General Medical Co., Los Angeles, CA) is an iontophoretic device that can be purchases for home use.
>
> * * * *
>
> ***In severe cases of intractable, disabling primary hyperhidrosis, surgical intervention has been utilized***. The principle of sympathectomy is to interrupt the nerve tracks and nodes that transmit the signals to the sweat glands. . . . ***The new technique of clipping the sympathetic nerve is generally viewed as the best option currently available*** because it is reversible by removing the nerve clip in patients with severe and unmanageable compensatory sweating. . . . (Emphasis added.)

175. A careful review of Aetna's own policies, and analysis relating to potential treatments for hyperhidrosis, demonstrates that repeated applications of chemical hyperhidrosis may be effective in cases of "light to moderate" hyperhidrosis; that oral prescription medication may be useful for "situational or episodic" hyperhidrosis; and that repeated application of Iontophoresis may provide "temporary relief" in "mild cases" of hyperhidrosis. However, the ***only*** treatment identified by Aetna for "severe cases of intractable, disabling primary hyperhidrosis" is "surgical intervention." Moreover, Aetna itself acknowledges that "the new technique of clipping the sympathetic nerve," which is precisely the ETS-C operative procedure performed by Dr. Egozi, "is generally viewed as the best option currently available."

176. Dr. Egozi, with the aid and assistance of AIH, only performs the ETS-C operative procedure on patients that he determines have "severe cases of intractable, disabling primary hyperhidrosis." Thus, even assuming that Aetna may properly seek recoupment of prior benefit payments without complying with ERISA requirements for adverse benefit determinations, Dr. Egozi's services were fully compliant with Aetna's policy and it has no valid basis for seeking

recoupment.

177. Even assuming that Aetna's policies could be deemed to require application of Iontophoresis prior to performing ETS-C, such policies must be rejected under ERISA as arbitrary and capricious. There is no basis for imposing such a requirement when Aetna already recognizes that Iontophoresis is only potentially effective for "mild cases," particularly given the treatments do not cure the problem, but must be given repeatedly, and that many find the electric current uncomfortable, the treatment expensive, time consuming, and the results not lasting long enough." CPB 0229; 0504.

178. The impropriety of Aetna *requiring* the use of Iontophoresis prior to treating severe cases of hyperhidrosis is highlighted by the fact that many other insurance companies refuse to cover that treatment at all. For example, according to Medical Policy Bulletin S-178 (Nov. 7, 2005) for Highmark:

> Iontophoresis (97033) . . . [is] considered experimental/investigational as treatment for primary hyperhidrosis (705.21). As such, iontophoretic devices used in the home for treatment of primary hyperhidrosis are not covered. The medical efficacy of iontophoresis . . . has not been established. These procedures are not eligible for reimbursement or payment. . . .

Similarly, according to the "Medical Policies – Medicine" (March 18, 2009) of BlueCross Blue Shield of Illinois, "Iontophoresis is considered experimental, investigational and unproven as treatment for hyperhidrosis." These conclusions are valid and appropriate, given that Iontophoresis is not FDA approved to treat hyperhidrosis, and is demonstrably unable to provide long-term relief to sufferers, unlike the treatment offered by Dr. Egozi.

179. Because Aetna must comply with ERISA in making its after-the-fact adverse benefit determinations, its coverage decisions must be based on the terms and conditions of its health care plan. Aetna may not rely on coverage restrictions, such as those contained in its

CPBs, if they are not disclosed in the plan documents, including the SPD. Thus, since Dr. Egozi satisfied the standard for providing the ETS-C operative procedure to his patients, his services should be covered under Aetna's plan terms. Aetna cannot impose additional requirements, including that Iontophoresis be used first, when such a requirement is not including in the plan.

180. Given the lack of medical support of the policy Aetna is seeking to impose on Dr. Egozi as a basis for seeking recoupment of prior benefit payments, and the fact that Aetna only made the decision to seek such recoupment after years of paying for the services provided by Dr. Egozi, it is evident that Aetna's decision was made solely as a cost-saving device, without regard to the best interest of its subscribers. It seeks to enhance its profits by forcing providers such as Dr. Egozi to repay vast sums of money to Aetna, without any basis for doing so, and, with regard to Dr. Egozi's practice, it seeks to save money by forcing patients to use a painful and ineffective home remedy as a substitute for an effective surgical alternative.

Plaintiff Egozi's Exhaustion of Administrative Remedies

181. To pursue its claim for recoupment against Dr. Egozi and AIH, Aetna retained the services of Tancredi Law, a law firm which, according to its website, is "dedicated exclusively to representing the Special Investigation Units of healthcare payors" in seeking to recover payments from providers. Tancredi Law (in the person of Barbara Tancredi) subsequently made repeated demands to Dr. Egozi and AIH for recoupment on behalf of, and as the agent for, Aetna.

182. In the November 27, 2007 demand letter sent to Dr. Egozi by Ms. Tancredi, Aetna cited to the fact that his Participation Agreement provided that he would only be reimbursed for providing "Covered Services," which it defined to include "[t]hose Medically Necessary Services . . . which a Member is entitled to receive under the terms and conditions of a Plan." The letter further added that "'Medically Necessary Services' exclude experimental services." As a result,

Aetna clearly confirmed that the primary basis for its effort to obtain a recoupment from Dr. Egozi arose from the terms of its own ERISA plans. Aetna then cited to CPB 0504 as "provid[ing] the conditions under which the surgeries in issue are covered by Aetna," adding that "[a]ll cases that do not meet these standards are defined as experimental and investigational." Aetna therefore contended that Dr. Egozi's provision of ETS-C operative procedures to his patients, which had previously been authorized and paid by Aetna were now deemed to be "experimental and investigational" under CPB 0504, a conclusion totally contrary to the language of CPB 0504 itself (see para. 86, *supra*).

183. Aetna failed to notify Dr. Egozi either in its 11/27/07 demand letter or in any other communications that Dr. Egozi had any appeal rights to challenge its after-the-fact adverse benefit determination. In its 11/27/07 letter, for example, merely stated: "Aetna is open to an amicable resolution of this matter. I must hear from you or your attorney no later than December 11, 2007 to discuss this matter further."

184. On December 10, 2007, prior to Aetna's arbitrarily imposed deadline, Dr. Egozi, through retained counsel, responded to Aetna's demand, expressly rejecting the basis for its contention that he owed any sums for prior benefit payments. Among other things, the letter to Aetna noted that Dr. Egozi and AIH had been working with Aetna to provide ETS-C operative procedures to Aetna insureds for some eight years before Aetna reversed its decision to claim that Dr. Egozi's procedures were not covered.

185. From then until early 2009, Dr. Egozi had extensive communications with Aetna challenging its after-the-fact adverse benefit determinations and seeking to persuade it to withdraw its demand. Aetna continued to press its demand, however, and at no time offered any means to appeal the issue or to resolve the dispute other than by settling by paying hundreds of

thousands of dollars to Aetna.

186. Aetna's blanket rejection of any effort by Dr. Egozi to appeal its adverse benefit determinations under ERISA is demonstrated in a July 9, 2009 letter he received from Ms. Tancredi. In it, she asserted that Dr. Egozi had no standing under ERISA to pursue claims, stating:

> [The ERISA appeals] are wrong on the applicable law. I refer you to *Physician's Multispecialty Group v. Health Care Plan of Horton Homes, Inc.*, 321 F.3d 1291 (2004). This is an 11th Circuit Court of Appeals decision in which the federal court ruled that a provider cannot maintain an ERISA action against a payor when the ERISA benefit plans at issue contain an anti-assignment provision. All ERISA plans insured or administered by Aetna contain such a provision and Florida is part of the 11th Circuit.

187. Through this letter, Aetna therefore explicitly rejected any consideration of Dr. Egozi's ERISA appeal. In doing so, it also misstated the law and the facts. First, while the 11th Circuit decision cited by Ms. Tancredi held that an "unambiguous" anti-assignment clause could be enforceable, it had to examine the specific language used in the plans to determine whether it was "unambiguous." Here, Ms. Tancredi has not cited or provided copies of any of the plan terms to prove her assertion that the Plans include anti-assignment clauses, thereby precluding Dr. Egozi from being able to challenge her assertions. Plaintiffs do not believe that most, let alone "all," of Aetna's policies have such exclusions.

188. Second, even if the Plans include a provision that precludes assigning benefits to a provider, ERISA regulations explicitly allow subscribers to authorize providers to represent them in pursuing ERISA claims. As stated in 29 CFR § 2560.503-1(b)(4), ERISA explicitly requires plans to have reasonable claims procedures, and such procedures "will be deemed to be reasonable only if . . . (4) The claims procedures do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an

adverse benefit determination." In this case, Dr. Egozi is acting as an authorized representative of his patients in pursuing this ERISA action. Thus, the anti-assignment clauses in Aetna plans, to the extent they even exist, do not preclude Dr. Egozi or other providers from representing their patients in ERISA actions. Ms. Tancredi's representations otherwise are false and misleading.

189. In her July 9, 2009 letter, Ms. Tancredi further refused to provide copies of any ERISA plan documents, as Dr. Egozi had requested, asserting that Aetna was not "responsible for providing them," notwithstanding that it was making adverse benefit determinations pursuant to those ERISA plans. Instead, Ms. Tancredi asserted that "Aetna's claims in this matter are state-law based, pure and simple," adding that "a breach of contract claim between a provider and payor is a state law claim not pre-empted by ERISA." In making this legal assertion, Ms. Tancredi again misstated the law, by ignoring the fact that Aetna's recoupment demand was based on a determination that the services performed by Dr. Egozi were "not covered" benefits or otherwise "not medically necessary," which required application of the terms and conditions of the applicable Aetna health care plans. ERISA therefore is directly implicated by Aetna's actions.

190. Ms. Tancredi ended her letter by seeking to intimidate Dr. Egozi by threatening litigation, stating that "Aetna is preparing litigation in this matter along the lines I outlined to your attorney previously." Use of such baseless threats are part of Aetna's scheme to discourage providers from challenging its improper recoupment demands.

191. In light of Aetna's actions, including communications from Ms. Tancredi, any administrative appeals that would otherwise be available to Dr. Egozi have clearly been exhausted or further pursuit of such internal appeals would be futile.

AETNA'S ERISA VIOLATIONS

192. During the course of his futile negotiations with Aetna, Dr. Egozi reminded Aetna that his patients remained liable for any portion of his bill that were not covered by Aetna. Thus, in a March 10, 2008 letter from an attorney representing Dr. Egozi and AIH to Aetna, it was stated:

> As indicated by the attached Acknowledgement, which the American Institute for Hyperhidrosis obtains from all of its patients, the patients agree in advance to pay for services which are not covered by insurance. Thus, if Aetna denies coverage for ETS procedures performed by Dr. Egozi, AIH and Dr. Egozi are not precluded by Dr. Egozi's contract with Aetna from seeking to recover the costs of surgery from such patients. In such event, AIH does intend to seek recovery from patients.

193. The standard form that AIH requires all of Dr. Egozi's patients to sign, entitled "Acknowledgement of Patient Responsibility," states:

> The benefits given to us by your insurance company are only an estimate of your benefits. Your insurance company will determine your actual benefits at the time your claims are processed. The amount you must pay prior to surgery represents a deposit on your actual out-of-pocket expenses for co-insurance and/or any uncovered services. After your claims are processed, there may be additional charges for which you are responsible.
>
> I acknowledge that I have read and understood this notice of patient responsibility and I agree that I will be responsible for all fees and charges that are not paid by any insurance carrier.

Because the only service at issue for these patients was the ETS-C operative procedure, it is clear that the patients understood what procedure was involved and that they would be responsible for the unpaid portions of the bill.

194. In light of the March 10, 2008 letter and the attached Acknowledgement, there is no question that Aetna was fully aware that its effort to obtain recoupment of previously paid benefits to Dr. Egozi and AIH would have a direct, adverse impact on Aetna members, who would be liable for the unpaid portion of the bill. Thus, Aetna also knew that its effort to obtain

a recoupment from Dr. Egozi and AIH represented an after-the-fact adverse benefit determination.

195. As Non-Par Providers, Drs. Restivo, Carnucci and Foglia are also entitled to bill their patients for any portions of their charges that are deemed not to be covered by Aetna. Similarly, Dr. Manz, as a Par provider, is entitled to balance bill his patients for services that Aetna deems not to be covered services. Further, the Individual Plaintiffs inform their patients in advance of their responsibility to pay for any portion of the bill that is not covered by Aetna.

196. In opposing Aetna's improper effort to compel repayments, the Individual Plaintiffs repeatedly sought further information from Aetna relating to its after-the-fact adverse benefit determinations. In March 6, 2008, for example, Dr. Egozi requested Aetna "provide revised Explanation of Benefit forms to all patients for whom reimbursement is being retroactively denied." Moreover, Dr. Egozi has also requested copies of the SPDs and other relevant plan documents that support Aetna's actions in denying the benefits. Dr. Restivo made similar demands, as detailed above. Aetna, however, refused to comply with such requests, in violation of ERISA.

197. Under ERISA, the term "adverse benefit determination" is defined as follows:

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

198. As the definition makes clear, Aetna's new policies as applied to the Individual

Plaintiffs constitute "adverse benefit determinations" under ERISA, in that the requests for recoupment are based on Aetna's determination that the services at issue were not "covered," including because they were "determined to be experimental or investigational."

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

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

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

201. Aetna utterly fails to comply with each ERISA requirement. After making benefit determinations for the Individual Plaintiffs, pursuant to which it found that the specific health care services at issue were Covered Benefits of its health care plans and subsequently paid benefits to the providers, Aetna reversed its coverage decisions. It subsequently informed the Individual Plaintiffs that it had determined that those same services were no longer deemed to be Covered Services and demanded that the providers repay Aetna.

202. Aetna's actions represent an after-the-fact adverse benefit determination under ERISA that would have the effect of creating new liabilities by the members to the providers. Yet, Aetna failed to inform its members of its actions, including by failing to provide necessary

disclosures or documentation required under ERISA either to the members or the providers.

203. Because of Aetna's failure to comply with ERISA's requirements governing adverse benefit determinations, its demands for recoupment are invalid and unenforceable, and its coverage determinations are arbitrary and capricious.

204. Even if Aetna had complied with the proper procedures under ERISA, it had and has no basis for making after-the-fact reversals of prior benefit determinations. The Individual Plaintiffs obtained the funds in good faith and acted based on the assumption that such payments were proper. As there is no dispute that the services at issue were provided by Plaintiffs, and that they billed and received payment for them in good faith, equity demands that the providers be entitled to keep such payments. Further, they have been severely prejudiced by Aetna's actions due, among other things, to the fact that a substantial period of time has passed since the medical procedures were performed and the providers will have substantial difficulty trying to obtain payments from their patients for the unpaid portion of the bills. Aetna should therefore be estopped from seeking recoupment or retaining any funds that were paid pursuant to its demands, or otherwise be found to have waived its ability to collect. Finally, Aetna's recoupment demands reflect an improper effort to obtain restitution in a manner that is impermissible under ERISA.

RICO ALLEGATIONS

The Recoupment Enterprise

205. Defendants and the individuals alleged below are "persons" within the meaning of 18 U.S.C. § 1961(3).

206. Based upon Plaintiffs' current knowledge, the following persons constitute a union or group of individuals associated in fact that Plaintiffs hereinafter refer to as the "Recoupment Enterprise":

(a) Defendants;

(b) The National Health Care Anti-Fraud Association ("NHCAA"), a national organization purportedly focused on "health care fraud" and comprising private healthcare insurers, including Aetna;

(c) International Business Machines Corporation ("IBM"), that under IBM's "Fraud and Abuse Management System" ("FAMS"), established in conjunction with Aetna performance software and analytics to pinpoint "questionable outlier behavior," through which Defendants share data and develop techniques and methods to perpetuate the fraudulent scheme to deprive Class Plaintiffs described above;

(d) Barbara Tancredi ("Ms. Tancredi"), an attorney licensed to practice in both the Commonwealth of Pennsylvania and the State of New Jersey with an office ("Tancredi Law") located at 600 West Germantown Pike, Suite 400, Plymouth Meeting, Pennsylvania, and retained by Aetna as legal counsel to Aetna's SIU. In her capacity as legal counsel to Aetna's SIU, Ms. Tancredi purportedly provided attorney oversight of the SIU's Provider Profiling, Post Payment Audits, Recoupment Efforts, and Pre-Payment Review. Moreover, Ms. Tancredi negotiates directly with Providers and their counsel on behalf of Aetna and Aetna's SIU to resolve disputes stemming from Aetna's Post Payment Audits. Additionally, in many cases, Ms. Tancredi herself performs Chiropractic Post Payment Audits and thereafter calculates and communicates, on behalf of Aetna and Aetna's SIU, Retroactive Benefit Determinations directly to Providers, and coordinates Aetna's corresponding Recoupment Efforts, including Pre-Payment Review. Ms. Tancredi is paid by Aetna based directly upon how much previously paid-reimbursement she is able to "recover" from Providers on behalf of Aetna and Aetna's SIU by and through Post Payment Audits, Retroactive Benefit Determinations, and Recoupment Efforts.

207. Defendants use, support and maintain the NHCAA as a vehicle for the communication, exchange, and dissemination of information necessary to effectuate Defendants' fraudulent recoupment scheme. With executive offices in Washington, DC, NHCAA identifies itself as "the leading national organization focused exclusively on the fight against health care fraud." It claims that it provides "unparalleled learning opportunities through the NHCAA Institute for Health Care Fraud Prevention." This "Institute" conducts numerous training programs for thousands of Special Investigations Unit personnel, and provides accreditation of these investigators as a Health Care Fraud Investigator ("AHFI"). Aetna, Inc., is a member organization of the NHCAA. Ten current Aetna executives received the AHFI designation by the NHCAA. Moreover, Aetna SIU Managers and Executives have, upon information and belief, served the NHCAA directly in a leadership capacity.

208. Although public law enforcement agencies may be involved in NHCAA, they are not members and are relegated to "liaisons." Only healthcare insurers such as Aetna, self-funded employers, contractors, and third-party administrators may become "member organizations."

209. The NHCAA Institute Special Training Programs, hosted throughout the year, "provide the invaluable opportunity for health care anti-fraud professionals to network with one another" and "keeping abreast of industry trends." One "learning product" is specifically entitled "Chiropractic Fraud: Schemes and Scoundrels," and is represented "to support and greatly enhance the knowledge of health care fraud investigators and law enforcement personnel charged with investigating chiropractic fraud cases." Other seminars include "Legal Issues for the Health Care Fraud Investigator," and "NHCAA Work Group Update" on the creation of "*industry norms* for the calculation of an investigative unit's return on investment" (emphasis added) and development of "standards for the practice of health care fraud investigations." A special

seminar, entitled "The Debate over Pre-Pay Fraud: Told by Those Who Know the Game," highlights the sharing of information concerning "retrospective fraud detection and investigation" and the automated systems need to implement such programs. The NHCAA Institute for Health Care Fraud Prevention sponsors an annual training conference, offering workshops on detection, investigation and prosecution tools.

210. Of special significance is the seminar on FAMS offered to NHCAA members entitled "Ending the 10% Debate – Scientifically Measuring the Amount of Fraud and Abuse in Your Claims," and presented by an executive of IBM. IBM, through its Center for Business Optimization is an NHCAA "Premier Supporting Member." IBM summarized the presentation as follows:

> Is your organization finding it difficult to measure the amount of claims that are fraudulent, wasteful, and abusive? Is your risk exposure increasing or decreasing over time? Which medical specialties have greater risk than others? What if you could scientifically measure the amount of fraud, waste, and abuse in your claims data – across all plans and geographies – without using a complicated tool to find the answer? Now you can! Identify where your exposures are and how your organization can direct investigative staff to immediately target leakage with the new IBM Fraud and Abuse Management System (FAMS) Dashboard. This new enhancement to FAMS measures fraud, waste, and abuse being committed by multiple provider types including, institutions, patients, etc. SIU Managers can now quickly view the types of schemes that are being perpetrated (overcharging, services not rendered, etc.) with one overall view of their claims data across multiple plans.

211. A key component of the NHCAA is the creation of opportunities for member organizations like Aetna to share healthcare anti-fraud information with other members, which include dozens of the major commercial healthcare insurers throughout the country. Indeed, the sharing of information by insurers "is fundamental to NHCAA's mission."

212. The sharing of anti-fraud information by the NHCAA is facilitated by at least four internal systems: (a) the Special Investigation Resource and Intelligence System ("SIRIS")

permits members to share information about "potential fraudulent activity" over the Web; (b) NHCAA hosts "information sharing meetings" where healthcare insurers and others "meet directly with their industry peers to share specific case information and information about new fraud schemes"; (c) healthcare insurer members receive case-specific requests for investigation assistance ("RIA") to "assist in case development" through facsimile, and insurer recipients follow up through telephone calls to the requesting insurer; and (d) the "Peer Experience Resource Center" ("PERC") permits members "to seek input from their industry peers about unusual, pressing or particularly challenging investigations or policy-related issues. PERC offers the ability to reach out to NHCAA's membership quickly and effectively."

213. The sharing of anti-fraud information by the NHCAA is also facilitated by the NHCAA's e-newsletters, "benchmarking" tools, email "alert service," and legal briefs made available to members.

214. An example of the sharing of information by the NHCAA is the article, "Understanding Chiropractic Fraud and Abuse," by Aetna employee John M. Kelly, AHFI, in the *Journal for Health Care Fraud Prevention*, published by NHCAA. After highlighting a number of chiropractic techniques deemed to be questionable or fraudulent, Kelly baldly states that chiropractors who are disappointed with insurer limits "should have cash only practices and not involve insurance in their payments for services rendered." He then adds:

> Once a provider decides to attempt to get reimbursement from an insurer, they have an obligation to accept the insurer's coverage policies and utilization review processes; regardless of their personal or professional philosophy. . . . In addition, the chiropractic community continues to publish opinions on how they should be less restricted and strive to lobby legislation that prohibits insurers from recovering overpayments. When the OIG issues reports with outrageous findings based on actual data, someone needs to act with a sense of urgency, and until enough people within chiropractic move to clean up their own house, payers will be forced to continue to review chiropractic with additional scrutiny.

215. Similarly, Kelly and Aetna Chiropractic Manager Robert Frank presented a seminar entitled "Chiropractic Fraud: Subluxation Frustration" at an NHCAA meeting in which they concluded that because chiropractic, although proven and valid, "remains to be properly defined and standardized," this ambiguity "has resulted in an atmosphere ripe with fraud and abuse."

216. IBM's FAMS was developed in conjunction with Aetna to identify "abusive behavior" by providers using data mining and other analytic techniques. As IBM states:

> Using a unique combination of data mining capabilities and graphical reporting tools, the system can identify potentially fraudulent and abusive behavior before a claim is paid or *retrospectively analyze providers' past behaviors to flag suspicious patterns.* In either case, the Fraud and Abuse Management System is designed to operate more swiftly and effectively than traditional, manual processes – sorting through tens of thousands of providers and tens of millions of claims in minutes, and then ranking providers as to their degree of potentially abusive behavior. [Emphasis added.]

217. Benjamin S. Wright, Business Systems Manager for Aetna's Special Investigations Unit, is specifically quoted in IBM's FAMS material:

> Through [the Fraud and Abuse Management System] Hospital Model, Aetna's special investigations unit (SIU) identified more than 200 facilities with questionable outlier behaviors. To date, the SIU has pinpointed more than US$20 million in potential recoveries.

218. IBM also stated that FAMS was developed "through collaborations with insurance organizations and through deep involvement in user groups." For example, with respect to the joint venture between IBM and Aetna in the development of FAMS, Aetna determined the parameters with advice from IBM consultants, after which Aetna directed its SIU personnel to begin FAMS-initiated investigations based on FAMS reports.

219. Aetna SIU investigators and executives and IBM consultants had quarterly FAMS meetings. Aetna investigators also directly accessed FAMS through an intranet portal.

220. Based on information provided by FAMS, Aetna's SIU identifies Providers or practices that exhibit potentially problematic or non-traditional billing patterns ("Provider Profiling") and thereafter commences a Post Payment Audit. Aetna and IBM designed FAMS to permit individual investigators or SIU personnel to manipulate the search data in such a fashion so as to permit targeted investigations of certain CPT codes and Provider billing patterns. Such targeted Provider Profiling is promoted by NHCAA and permitted by Ms. Tancredi.

221. FAMS is also used to identify Providers whom Aetna will place in Pre-Payment Review, a process whereby Aetna's SIU investigators "flag" a provider's account in Aetna's claims processing system. Once flagged, all the subsequent claims submitted by this Provider are no longer auto-adjudicated. Instead, every claim a Provider submits to Aetna for care rendered to Aetna's Insureds is purportedly reviewed prior to payment and, in practice, uniformly denied regardless of the validity of the claim, and without providing a means by which to appeal. Pre-Payment Review is imposed at the onset of a Post Payment Audit, or at anytime thereafter; particularly if a Provider is not willing to "settle" a dispute over Retroactive Benefit Determinations. Specifically, Pre-Payment Review is most often used by Aetna's SIU to force a Provider into settlement by effectively cutting off all reimbursement by Aetna to the Provider and thereafter placing impossible obstacles on the Provider to secure current payments. The software by which these Pre-Payment "flags" are placed upon certain Provider accounts was, upon information and belief, also developed in conjunction with IBM. The Practice of utilizing Pre-Payment Review is, upon information and belief, a practice sanctioned by NHCAA.

222. Often, claims denied as part of Pre-Payment Review are denied in whole without any individual assessment of the validity of the underlying claims, even if the Provider supplied the corresponding treatment records so as to permit an actual review pre-payment. In EOBs sent

by U.S. Mail or electronically distributed to Providers, Aetna denied such claims and provided intentionally misleading explanations.

223. As part of the Post Payment Audit process facilitated by IBM, sanctioned by NHCAA, and supervised in part by Ms. Tancredi, Aetna's SIU investigators often: (1) sent correspondence to the targeted Provider requesting a "sample" of patient records to be reviewed by Aetna's SIU; and (2) prepared questionnaires sent by U.S. Mail to the home addresses of patients of the Providers under investigation. These patients were invited to mail back the completed questionnaires or speak to an Aetna SIU investigator by telephone.

224. Upon completion of a review, Aetna's SIU investigators then send a letter to the Provider representing that the Provider was overpaid by a specific amount based upon Retroactive Benefit Determinations and demanding immediate repayment without offering SPDs or any other explanatory documentation and without providing an appeal mechanism.

225. Providers also contact the Aetna SIU investigator by telephone. However, these investigators were specifically instructed by SIU managers and Ms. Tancredi: (1) to engage in Recoupment Efforts utilizing the mail and electronic wire communications for monies paid to Providers on behalf of Aetna Insureds on claims for which Aetna had no lawful right to repayment; (2) not to provide SPDs or any other explanatory documentation; (3) not to discuss or otherwise provide an appeal mechanism for claims denied as part of either Retroactive Benefit Determinations or Pre-Payment Review; and (4) not to reveal that they had direct control over the provider's current claims that were denied as part of Pre-Payment Review, despite the fact that that the investigator had originated the "pending" of current claims in conjunction with past claims sought to be recouped as Retroactive Benefit Determinations.

226. While the Defendants participate in and are members and part of the Recoupment

Enterprise, they also have an existence separate and distinct from this association-in-fact enterprise.

227. The Recoupment Enterprise is an ongoing organization that engages in, and whose activities affect, interstate commerce.

228. The Recoupment Enterprise has and continues to have an ascertainable structure and function separate and apart from the pattern of racketeering activity in which Defendants have engaged. The members of the Recoupment Enterprise function as a structured and continuous unit, and perform roles consistent with this structure. The members of the Recoupment Enterprise performed certain legitimate and lawful activities that are not being challenged here including, but not limited to, investigating and preventing insurance fraud. However, recoupment of certain prior payments was not legitimate when it was part of Defendants' fraudulent scheme in detriment to Class Plaintiffs and the Class. The members of the Recoupment Enterprise used the Recoupment Enterprise's structure to carry out the above fraudulent and unlawful activities. In order to recoup monies successfully in the manner set forth above, Defendants needed a system that enabled them to manipulate and control current payments to Class Plaintiffs and conceal the manner in which that was done. The Recoupment Enterprise provided Defendants with that system and ability, and their control of and participation in it was necessary for the successful operation of their scheme. The purpose of the Recoupment Enterprise was to create a mechanism by which Aetna could recoup benefit payments for services, but to do so through a means that providers would be unable to challenge effectively.

229. As set forth above, the Recoupment Enterprise has an ascertainable structure separate and apart from the pattern of racketeering activity in which the Defendants engage.

PREDICATE ACTS

230. 18 U.S.C. §1961(1) provides that "racketeering activity" includes any act indictable under 18 U.S.C. § 1341 (relating to mail fraud) and 18 U.S.C. § 1343 (relating to wire fraud). As set forth below, Defendants have and continue to engage in conduct violating these laws to effectuate their scheme.

Violations of 18 U.S.C. §§ 1341 and 1343

231. For the purpose of executing and/or attempting to execute the above described scheme to defraud or obtain money by means of false pretenses, representations or promises, the Defendants, in violation of 18 U.S.C. § 1341, placed in post offices and/or in authorized repositories matter and things to be sent or delivered by the Postal Service, caused matter and things to be delivered by commercial interstate carrier, and received matter and things from the Postal Service or commercial interstate carriers, including but not limited to EOBs, correspondence, and recoupment demands.

232. For the purpose of executing and/or attempting to execute the above described scheme to defraud or obtain money by means of false pretenses, representations or promises, the Defendants, also in violation of 18 U.S.C. § 1343, transmitted and received by wire and through other interstate electronic media, matter and things which include but are not limited to recoupment demands, and Defendants' requests for additional information that were communicated by facsimile.

233. Other matter and things sent through or received from the Postal Service, commercial carrier or interstate wire transmission by Defendants included information or communications in furtherance of or necessary to effectuate the scheme.

234. The Defendants' misrepresentations, acts of concealment and failures to disclose

were made for the purpose of deceiving Plaintiffs and the Class and obtaining their property for the Defendants' gain.

235. The Defendants either knew or recklessly disregarded the fact that the misrepresentations and omissions described above were material.

236. As a result, Defendants obtained money and property belonging to Class Plaintiffs, and Class Plaintiffs were injured in their business or property by the Defendants' overt acts of mail and wire fraud.

PATTERN OF RACKETEERING ACTIVITY

237. The Defendants engaged in a "pattern of racketeering activity," as defined by 18 U.S.C. § 1961(5), by committing or aiding and abetting in the commission of at least two acts of racketeering activity, that is, indictable violations of 18 U.S.C. §§ 1341 and 1343 as described above, within the past ten years. In fact, the Defendants have committed numerous acts of racketeering activity. Each act of racketeering activity was related, had a similar purpose, involved the same or similar participants and method of commission, had similar results and impacted similar victims, including Plaintiffs.

238. The multiple acts of racketeering activity that Defendants committed were related to each other and amount to and pose a threat of continued racketeering activity, and therefore constitute a "pattern of racketeering activity" as defined in 18 U.S.C. § 1961(5).

239. A few representative examples of the types of predicate acts committed by Defendants pursuant to their scheme to defraud the Plaintiffs are alleged above and any supplements or further amendments hereto.

RICO VIOLATIONS

18 U.S.C. § 1962(c)

240. 18 U.S.C. § 1962(c) provides that it "shall be unlawful for any person employed by or associated with any enterprise engaged in, or the activities of which affect, interstate or foreign commerce, to conduct or participate, directly or indirectly, in the conduct of such enterprises affairs through a pattern of racketeering activity…"

241. Through the patterns of racketeering activities outlined above, the Defendants have violated 18 U.S.C. § 1962(c), and have also conducted and participated in the affairs of the Recoupment Enterprise.

242. The Individual Plaintiffs have been injured as a result of Aetna's RICO violations, including by having benefits denied based on Aetna's invalid benefit denials and inappropriate delays in making benefit determinations. The Association Plaintiffs have also been injured by Aetna's wrongful conduct. Aetna's wrongful conduct causes direct injury to members of the Association Plaintiffs by delaying, denying, impeding and reducing lawful compensation for services provided to Aetna's Insureds.

243. Aetna's wrongful conduct also causes direct injury to the Association Plaintiffs because they have been, and continue to expend time and resources in dealing with Defendants' practices. This frustrates the Association Plaintiffs' purpose which is to uphold the provider patient relationship and ensure the delivery of quality medical care to patients.

CLASS DEFINITIONS

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

> All health care providers who, from six years prior to the filing date of this action to its final termination ("ERISA Class Period"), have provided health care services to patients insured under ERISA health care plans insured or administered by Aetna, and who, after having received payments from Aetna, have been subjected to retroactive requests for repayment of all or some portion of

such payments and Pre-Payment Reviews.

245. The Individual Plaintiffs further bring this action on their own behalf and on behalf of a "RICO Recoupment Class," defined as:

> All health care providers who, from four years prior to the filing date of this action to its final termination ("RICO Class Period"), have provided health care services to patients insured under health care plans insured or administered by Aetna, and who, after having received payments from Aetna, have been subjected to retroactive requests for repayment of all or some portion of such payments and Pre-Payment Reviews.

246. The Individual Plaintiffs bring claims against Aetna on their own behalf and on behalf of the ERISA and RICO Recoupment Classes (1) to enjoin Aetna from taking further stops to compel a return of prior payments of plan benefits; (2) to order Aetna to return to all Class members who have paid money to Aetna in response to such demands all such funds, plus interest; and (3) to declare that any future efforts to recoup payments for errors or mistakes in prior payments must comply with the specific requirements under ERISA for adverse benefit determinations.

247. Plaintiffs Restivo, Carnucci, Foglia and Manz further represent on their own behalf and on behalf of a "Chiropractic Subclass," defined as:

> All health care providers who, from six years prior to the filing date of this action to its final termination ("Chiropractic Subclass Period"), have provided the chiropractic services described herein to patients insured under ERISA health care plans insured or administered by Aetna and where such services have been deemed by Aetna to be not covered under its healthcare plans pursuant to their "experimental" or "investigational" exclusions.

248. Plaintiffs Restivo, Carnucci, Foglia and Manz bring claims against Aetna on their own behalf and on behalf of the Chiropractic Subclass (1) to enjoin Aetna from declaring the chiropractic services described herein as not being covered under its health care plans pursuant to their "experimental" or "investigational" exclusions; (2) to enjoin Aetna from requiring members

of the Chiropractic Subclass to submit medical records for all or a substantial portion of all of their Aetna Insureds prior to receiving payment; (3) to order Aetna to issue new benefits to members of the Chiropractic Subclass whose claims for benefits have been denied in whole or in part; and (4) to require Aetna to return any funds it has received from members of the Chiropractic Subclass as a result of its recoupment scheme as detailed herein.

249. Plaintiff Egozi further represents on his own behalf and on behalf of an "ETS Subclass," defined as:

> All health care providers who, from six years prior to the filing date of this action to its final termination ("ETS Subclass Period"), have provided an ETS operative procedure to patients insured under ERISA health care plans insured or administered by Aetna and where such services have been deemed by Aetna to be not covered under its healthcare plans due to the failure of the provider to require the patient first to attempt the use of iontophoresis.

250. Plaintiff Egozi brings claims against Aetna on his own behalf and on behalf of the ETS Subclass (1) to enjoin Aetna from declaring the ETS operative procedure as not being covered under its health care plans due to the failure of the provider to require the patient first to attempt the use of iontophoresis; (2) to enjoin Aetna from requiring members of the ETS Subclass to submit medical records for all or a substantial portion of all of their Aetna Insureds prior to receiving payment; (3) to order Aetna to issue new benefits to members of the ETS Subclass whose claims for benefits have been denied in whole or in part; and (4) to require Aetna to return any funds it has received from members of the ETS Subclass as a result of its recoupment scheme as detailed herein.

COMMON CLASS CLAIMS, ISSUES AND DEFENSES FOR THE CLASS

251. The following common class claims, issues and defenses for the Individual Plaintiffs and the Classes arise for the defined Class Periods:

(1) Whether Aetna's effort to compel recoupment of previously paid benefits as describer herein violated ERISA or other applicable law;

(2) Whether Aetna's determination that the chiropractic services detailed herein fall within the "experimental" and "investigational" exclusions of its health care plans is in violation of ERISA, or other applicable law;

(3) Whether Aetna's determination that the ETS operative procedure is not a Covered Benefit unless the patient first tries Iontophoresis is in violation of ERISA, or other applicable law;

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

(5) Whether Aetna'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 Aetna subscribers, or whether Aetna is otherwise estopped from asserting such an objection;

(7) Whether Class Members may recover amounts repaid to Aetna or unpaid benefits and if so, the amount they should receive;

(8) Whether Aetna's failure to provide accurate plan documents, EOCs, SPDs and other information upon request entitles Class members to relief;

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

(10) Whether Aetna's claims review procedures comply with ERISA;

(11) The standard of review applicable to review Aetna's benefit determinations;

(12) Whether Aetna violated its fiduciary or other legal duties owed to Plaintiffs Restivo, Carnucci and Foglia and the Class Members when it made Nonpar benefit determinations or otherwise engaged in the conduct alleged in this Complaint;

(13) Whether any settlement agreements entered into by Aetna with providers pursuant to its Recoupment Efforts should be rescinded, with any received payments returned;

(14) Whether Aetna's EOBs and other communications with its Members violated ERISA or other applicable law;

(15) Whether Aetna engaged in a pattern of racketeering activity, as defined by RICO, by and through the conduct of the Recoupment Enterprise described in this Complaint;

(16) Whether Aetna Insureds in ERISA and non-ERISA plans are entitled to treble damages or other relief for Aetna's violations of RICO; and

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

ADDITIONAL CLASS ACTION ALLEGATIONS

252. The members of the Classes are so numerous that joinder of all members is impracticable. Upon information and belief, the Classes consists of thousands of healthcare providers in commercial group health plans insured, offered, or administered by Aetna. The precise number of members in the Classes are within Aetna'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.

253. The Individual Plaintiffs' claims are typical of the claims of the Class members because, as a result of the conduct alleged herein, Aetna has breached its statutory and contractual obligations to the Individual Plaintiffs and the Classes through and by uniform patterns or practices as described above, including but not limited to its effort to compel repayment of prior paid benefits; its adoption of standard policies to deny coverage for the specified CPT Codes as falling within the experimental and investigational exclusion in its health care plans; and its adoption of standard policies to deny coverage for ETS in the absence of use of Iontophoresis.

254. The Individual Plaintiffs 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 RICO claims and have no interests antagonistic to or in conflict with those of the Class. For

these reasons, Plaintiffs Restivo, Carnucci, Foglia, Manz and Egozi are adequate class representatives.

255. 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 Aetna.

256. 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. Aetna maintains computerized claims information that enables it to calculate the amounts for which it has demanded recoupment and the amount it has received from Class Members as a result of its actions alleged herein. Given the uniform policy and practices at issue, there will also be no difficulty in the management of this litigation as a class action.

COUNT I

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

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

258. The Individual Plaintiffs have standing to pursue these claims as assignees of their patients' benefits claims, and the Association Plaintiffs have standing to pursue these claims on behalf of their members through associational standing.

259. Aetna must pay benefits to Aetna Insureds who are insured, funded or administered by Aetna pursuant to the terms of their ERISA plans.

260. To the extent Aetna determined that charges submitted for reimbursement by the Individual Plaintiffs and the members of the Recoupment Class are no longer Covered Services under its health care plans, such a finding is an "adverse benefit determination" under ERISA.

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

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

263. Aetna's lack of disclosure to its members or their providers relating to adverse benefit determinations, as required under ERISA, violated its legal obligations.

264. Due to Aetna's failure to comply with ERISA in pursuing Recoupment Efforts, Aetna is estopped from pursuing such efforts and, further, is required to repay any members of the Recoupment Class who have paid sums to Aetna in response to its recoupment demands.

265. The Individual Plaintiffs, on their own behalf and on behalf of the members of the Classes, seek unpaid benefits, interest back to the date their claims were originally submitted to Aetna, withdrawal of all claims for rescission or other relief against the Individual Plaintiffs or the members of the Classes, and repayment of any amounts paid by members of the Classes in response to any recoupment letters or demands. The Individual Plaintiffs and the Association Plaintiffs also sue for declaratory and injunctive relief related to enforcement of plan terms, and to clarify rights to future benefits. They further request attorneys' fees, costs, prejudgment interest and other appropriate relief against Aetna.

COUNT II

CLAIM FOR BENEFITS UNDER
GROUP PLANS GOVERNED BY ERISA
(on behalf of the Chiropractic Subclass)

266. 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)(1)(B).

267. Aetna made adverse benefit determinations with regard to the coverage for various services provided by Plaintiffs Restivo, Carnucci, Manz and Foglia, and members of the Chiropractic Subclass, including that payment for CPT Code 97140 for both joint and soft tissue manual techniques was denied; that use of a Dry Hydrotherapy Bed was improperly billed based on CPT Code 97022, Whirlpool, and that "Aquamassage," the service provided through such a mechanism was not covered as "experimental and investigational"; that the use of Intersegmental Traction Tables (billed under CPT Code 97012, Mechanical Traction) was not a covered service because it was deemed to be "experimental and investigational"; that the use of the DRX9000 and similar items for mechanical traction (billed under CPT Code 97012, Mechanical Traction) was not a covered service because it was deemed to be "experimental and investigational"; that Surface Scanning Electromyography ("SEMG") (billed under CPT Code 95999) was not a covered service because it was deemed to be "experimental and investigational"); and that billing for a 5 region CMT (billed under CPT Code 98942) should be downcoded to a 3-4 region CMT (billed under CPT Code 98941) or a 1-2 region CMT (billed under CPT Code 98940).

268. With regard to each of the above summarized adverse benefit determinations, Aetna violated its legal obligations under ERISA and federal common law due to its failure to comply ERISA regulations and requirements.

269. Aetna's lack of disclosure to its members or their providers relating to adverse benefit determinations, as required under ERISA, violated its legal obligations.

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

271. The chiropractic services identified above are appropriate treatments generally accepted in the chiropractic community and do not constitute "experimental or investigational" treatments under the terms and conditions of Aetna's ERISA health care plans.

272. In making its adverse benefit determinations, Aetna discouraged or penalized its members' use of Nonpar providers, such as by making the benefit denials or reductions detailed herein. In doing so, Aetna further violated ERISA, section 510, by unlawfully discriminating against its members who sought to exercise their rights under ERISA to use Nonpar services and against their Nonpar providers.

273. Plaintiffs Restivo, Carnucci, Manz and Foglia, on their own behalf and on behalf of the members of the Chiropractic Subclass, seek unpaid benefits relating to the services described herein and interest back to the date their claims were originally submitted to Aetna. Plaintiffs Restivo, Carnucci, Manz and Foglia, and the Association Plaintiffs also sue for declaratory and injunctive relief related to enforcement of plan terms, and to clarify rights to future benefits. They further request attorneys' fees, costs, prejudgment interest and other appropriate relief against Aetna.

COUNT III

CLAIM FOR BENEFITS UNDER GROUP PLANS GOVERNED BY ERISA

(on behalf of the ETS Subclass)

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

275. Aetna has made adverse benefit determinations with regard to the coverage for ETS operative services provided by Plaintiff Egozi and members of the ETS Subclass, requiring use of other methods, including iontophoresis, before ETS will be deemed to be a covered service.

276. With regard to each of the above summarized adverse benefit determinations, Aetna violated its legal obligations under ERISA and federal common law due to its failure to comply ERISA regulations and requirements.

277. Aetna's lack of disclosure to its members or their providers relating to adverse benefit determinations, as required under ERISA, violated its legal obligations.

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

279. ETS is an appropriate treatment generally accepted in the medical community for treating severe and constant cases of hyperhidrosis. Iontophoresis is not an appropriate treatment for such a condition. Aetna's effort to compel Dr. Egozi and other members of the ETS Subclass to first use Iontophoresis violates the terms and conditions of its own health care plans, as well as its internal policies as reflected in it CPBs.

280. Plaintiff Egozi, on his own behalf and on behalf of the members of the ETS Subclass, seeks unpaid benefits relating to the services described herein and interest back to the date their claims were originally submitted to Aetna. Plaintiff Egozi also sues for declaratory and injunctive relief related to enforcement of plan terms, and to clarify rights to future benefits. He further request attorneys' fees, costs, prejudgment interest and other appropriate relief against Aetna.

COUNT IV

FAILURE TO PROVIDE FULL & FAIR REVIEW AS REQUIRED BY ERISA

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

282. Aetna functioned and continues to function as the "plan administrator" within the meaning of such term under ERISA. During the Class Period, the Individual Plaintiffs – as assignees of the ERISA benefits payable to their patients – were entitled to receive a "full and fair review" of all claims denied by Aetna, and entitled to assert a claim under 29 U.S.C. § 1132(a)(3) for failure to comply with these requirements.

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

284. Aetna also failed to supply accurate EOCs, SPDs and other required information to under ERISA, in violation of 29 U.S.C. § 1022.

285. By engaging in the conduct described herein, including use of improper, invalid and undisclosed policies relating to chiropractic and ETS services, baseless threats regarding overpayments and referrals to collection agencies, and other systematic benefit reductions without disclosure or authority under the Plans, Aetna failed to comply with ERISA, its regulations and federal common law.

286. As a result, Aetna failed to provide a "full and fair review," failed to provide

reasonable claims procedures, and failed to make necessary disclosures to its Members.

287. Appeals of the Individual Plaintiffs and members of the Classes should be deemed exhausted or excused by virtue, *inter alia*, of Aetna's numerous procedural and substantive violations.

288. The failed appeals of the Individual Plaintiffs, as alleged in this Complaint, show the futility of exhausting appeals to Aetna. Exhaustion of internal appeals under ERISA should, therefore, be deemed to be futile.

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

COUNT V

VIOLATIONS OF RICO 18 U.S.C. § 1962(c)

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

291. This claim for relief arises under 18 U.S.C. § 1964(c).

292. As set forth above, Defendants violated 18 U.S.C. § 1962(c) by conducting, or participating directly or indirectly in the conduct of, the affairs of the Recoupment Enterprise through a pattern of racketeering.

293. As a direct and proximate result, Plaintiffs have been injured in their business or property by both the predicate acts that make up the Defendants' pattern of racketeering activity and their investment and reinvestment of income therefrom to operate, expand and perpetuate the

Recoupment Enterprise.

294. Specifically, Plaintiffs have been injured in their business or property by the recoupment of payments for covered services that they have rendered to Defendants' Insureds.

COUNT VI

DECLARATORY AND INJUNCTIVE RELIEF UNDER 18 U.S.C. § 1964(a)

295. The allegations contained in this Complaint are realleged and incorporated by reference as if fully set forth herein. This claim arises under 18 U.S.C. § 1964(a), which authorizes the district courts to enjoin violations of 18 U.S.C. § 1962, and under 28 U.S.C. § 2201 which authorizes associated declaratory relief.

296. As set forth in the Count 5, Defendants violated 18 U.S.C. § 1962(c) and will continue to do so in the future.

297. A money judgment in this case will only compensate Class Plaintiffs for past losses. It will not stop Defendants from continuing to confiscate the money earned by, and necessary to maintain the medical practice of, Class Plaintiffs.

298. No individual provider has a practical or adequate remedy, either administratively or at law, to recover these future losses.

299. Where multiple lawsuits are required to redress repeated statutory violations, breaches of contract or other wrongs, there is no adequate remedy at law and irreparable harm exists.

300. Enjoining Defendants from committing these RICO violations in the future and/or declaring their invalidity is appropriate as Plaintiffs have no adequate remedy at law, and will, as set forth above, suffer irreparable harm in the absence of the Court's declaratory and injunctive relief.

COUNT VII

EQUITABLE RELIEF

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

302. Aetna has issued demand letters to the Individual Plaintiffs and other members of the Recoupment Class seeking to compel repayment of previously paid benefits. In so doing, Aetna failed to comply with the terms and conditions of its healthcare care plans, both those under ERISA and otherwise, with regard to making adverse benefit determinations.

303. Aetna has no legal basis upon which to pursue recoupment from the Individual Plaintiffs and other members of the Recoupment Class, but is merely seeking to coerce payments for after-the-fact changes in policy by Aetna.

304. Equity demands that Aetna's Recoupment Efforts be enjoined. The Individual Plaintiffs and other members of the Recoupment Class have previously accepted in good faith benefit payments from Aetna and have foregone pursuing payments of those amounts from their Aetna patients. Because of Aetna's after-the-fact adverse benefit determinations, the ability of the Individual Plaintiffs and other members of the Recoupment Class to obtain payment from their Aetna patients for the amounts Aetna now seeks to recoup has been severely prejudiced.

305. The Individual Plaintiffs and the Association Plaintiffs seek appropriate declaratory and injunctive relief to enjoin Aetna from pursuing its effort to coerce recoupment and, further, to order Aetna to provide restitution in the form of a return of any funds it has received from providers as a result of its Recoupment Efforts.

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

A. Certifying the Classes, as set forth in this Complaint, and appointing Plaintiffs Restivo, Carnucci, Manz, Foglia and Egozi Class representatives for the respective Classes.

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

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

D. Declaring that Aetna violated its disclosure and related obligations under ERISA and federal common law, including under 29 U.S.C. § 1022, for which Plaintiffs and the Classes are entitled to injunctive, declaratory and other equitable relief;

E. Declaring that Aetna violated federal claims procedures, and awarding Plaintiffs and the Classes declaratory and injunctive relief to remedy such violations;

F. Ordering Aetna to recalculate and issue unpaid benefits to the Individual Plaintiffs and members of the Classes who were underpaid as a result of Aetna's actions as detailed herein;

G. Enjoining Aetna from continuing to pursue its Recoupment Efforts as detailed herein, and ordering it to pay restitution in the form of a return of any sums previously paid by providers in response to Aetna's Recoupment Efforts;

H. Awarding Plaintiffs and the Members of the RICO Class compensatory damages, trebled where required by law, and disbursements and expenses of this action, including reasonable counsel fees, in amounts to be determined by the Court and other appropriate relief;

I. Awarding the Individual Plaintiffs and Plaintiffs ANJC and NYCC, disbursements and expenses of this action, including reasonable attorneys' fees, in amounts to be determined by the Court and other appropriate relief;

J. Awarding interest from the date of initial benefit reductions for the Individual Plaintiffs and members of the Classes for all unpaid amounts; and

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

JURY DEMAND

Plaintiffs demand trial by jury on all issues so triable.

Dated: July 29, 2009

Respectfully submitted,

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