UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
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LONG ISLAND NEUROLOGICAL ASSOCIATES, P.C.,

Plaintiff,

- against –

HIGHMARK BLUE SHIELD and REED SMITH LLP,

Defendants.
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BenefitsLink Note: Correct Plaintiff is Long Island Neurosurgical Associates, PC -- see original complaint attached at the end of this Opinion

MEMORANDUM AND ORDER
2:18-cv-81 (DRH)(AYS)

APPEARANCES

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HURLEY, Senior District Judge:

INTRODUCTION

Plaintiff Long Island Neurological Associates, P.C. ("Plaintiff") brought this action against Defendants Highmark Blue Shield ("Highmark") and Reed Smith LLP ("Reed Smith,"

collectively "Defendants") for under-reimbursement for surgical services pursuant to the Employment Retirement Income Security Act. (Am. Compl. ¶¶ 1, 8.)

Presently before the Court is Defendants motion to dismiss pursuant to Fed. R. Civ. P. ("Rule") 12(b)(1) and Rule 12(b)(6).

BACKGROUND

The following relevant facts come from the Amended Complaint ("Am. Compl.") and are assumed true for purposes of this motion.

This matter concerns a 4-year old girl ("Patient") who is allegedly insured through a Group Benefits Program sponsored by Defendant Reed Smith. (Am. Compl. ¶ 1 – 2.) Defendant Highmark is the "Claims Administrator" and the "Third-Party Administrator" for Reed Smith's insurance plan ("Plan"). (*Id.*¶ 1, 12). On January 12, 2016, the Patient was admitted to Cohen Children's Medical Center in New Hyde Park ("Hospital") with multiple sutural synostosis and degenerating cranial deformity. (*Id.*¶ 3.) A physician, Dr. Schneider, examined the Patient and determined she required surgery to treat her condition. (*Id.*) Dr. Schneider performed the surgery the same day. (*Id.* ¶ 17.) Dr. Schneider was the only pediatric neurosurgeon with privileges at the Hospital who could perform the complex surgery the Patient required, which is to say that there were no "in-network" surgeons who could perform the surgery at the Hospital. (*Id.* ¶ 34.) In fact, Defendant Highmark has no in-network pediatric neurosurgeons anywhere in Nassau County. (*Id.* ¶ 35.)

Plaintiff subsequently submitted an invoice that it summarizes as follows: "(i) CPT Code 21175 with modifier 80 in the amount of $24,166.50, but Highmark allowed only $888.23 thereof; (ii) CPT Code 15732 (2 units at $16,500 each) in the total amount of $33,000, but Highmark allowed only $2,461.10 thereof; and (iii) CPT Code 61559 with a modifier 22 in the

amount of $66,000, but Highmark allowed only $5,489.70 thereof." (*Id.*) In other words, out of the $123,166.50 billed, the total amount allowed was $8,839.03. (*Id.* ¶ 19.) Defendant Highmark's explanation of benefits dated February 29, 2016 stated that Plaintiff was out of network and that the Patient was responsible for the amount not covered. (*Id.* ¶ 20.) Plaintiff filed an initial appeal on April 7, 2016, explaining that the rates were based on the "usual and customary treatment charges for the specialty and the geographic region where the treatment was provided." (*Id.* ¶ 21.) Plaintiff requested the applicable policy language that justified the reduction as well as the data used to establish the reduction rate. (*Id.*) Defendant Highmark never provided the additional documentation requested and denied the request for additional reimbursement. (*Id.* ¶ 22.)

Plaintiff filed a Second Level Appeal on October 7, 2016, reiterating that it had never received the applicable fee schedule or policy guidelines to support the payment method. (*Id.* ¶ 23.) Defendant Highmark denied the Second Level Appeal on October 7, 2016, again failing to provide any of the requested information. (*Id.* ¶ 25.) On January 6, 2017, Highmark sent a letter to Plaintiff indicating that the Patient was only entitled to two levels of appeal and that all appeals were exhausted. (*Id.* ¶ 25.) In this letter, Defendant Highmark further stated that when covered services are provided outside of the geographic area by non-participating providers, the Plan allowance is based upon the prices established by the local Highmark licensee. (*Id.*) Plaintiff alleges that Defendant Highmark established the rates. (*Id.*)

Around this time, Dr. Schneider sent a letter explaining the surgery to Defendant Highmark. (*Id.* ¶ 26.) On February 21, 2017, Defendant Highmark responded to Dr. Schneider's letter stating that the claim was reviewed and that the additional information submitted by Dr. Schneider did not substantiate the complexity or necessity for extended time to warrant

additional reimbursement. (*Id.*) In all of Defendant Highmark's communications with Plaintiff and its employees, Highmark never explained how it processed the claim or the terms of the Summary Plan Description ("SPD") that controlled. (*Id.* ¶

On April 5, 2017, Plaintiff's outside counsel sent an appeal letter to Defendant Highmark requesting that it reprocess the claim. (*Id.* ¶ 28.) Defendant Highmark did not respond for almost eight months – finally sending a letter on December 4, 2017, stating that the claim was "processed correctly in accordance with the non-contracted provider allowance established under the member's benefits agreement[.]" (*Id.*) Highmark did not provide a copy of the referenced agreement. (*Id.*) At some time between the surgery in 2016 and the time this action was commenced, the Patient's parents signed an Assignment of Insurance Benefits that gave Plaintiff the right to file claims and appeals, and institute necessary litigation on the Patient's behalf. (*Id.* ¶ 45.) The Patient further designated Plaintiff her Authorized Representative under 29 C.F.R. § 2560.5031(b)(4). (*Id.*)

Plaintiff commenced the instant action on December 8, 2017, by filing a Complaint in State Court. On January 5, 2018, Defendant Highmark removed the action to Federal Court. Plaintiff filed an Amended Complaint on February 28, 2018, and Defendants Highmark and Reed Smith moved to dismiss the action on June 19, 2018. On June 22, 2018, Plaintiff requested leave to file a sur-reply on the single issue of whether the Administrative Service Agreement ("ASA") is an ERISA Plan Document. The Court granted such leave and Plaintiff filed its sur-reply on July 20, 2018. The Court will analyze this threshold question first.

DISCUSSION

I. Whether the ASA is a Plan Document

Defendants' entire argument advanced in support of this motion to dismiss hinges on their assertion that the anti-assignment provision in the ASA precludes assignment by the Patient of her rights to Plaintiff. (*See* Reply Mem. in Supp. [ECF No. 21] at 2.) Plaintiff asserts that the ASA was never distributed or available to the Patient or other Plan beneficiaries. (Sur-reply [ECF No. 24] at 3.) Defendants do not say otherwise in any of their papers. Moreover, Defendants effectively concede that there is *no* anti-assignment provision in the SPD that was provided to Plaintiff's family as beneficiaries of the Plan. Plaintiff, in turn, concedes that if there is a valid anti-assignment provision that is applicable, Plaintiff is barred from bringing the instant action. (*See* Mem. in Opp [ECF No. 20] at 4.) Thus, the determinative question in this matter is whether the anti-assignment provision in the ASA applies to the Patient's assignment of her rights and benefits under the Plan.

As an initial matter, the Court notes that there is a dispute over whether Third Circuit or Second Circuit case law should control. Defendants argue that the ASA provides that Pennsylvania substantive law should apply, so the Court should look to Third Circuit precedent. (Mem. in Supp. at 4.) Plaintiff, on the other hand, cites to Second Circuit precedent throughout its papers. (*See, e.g.*, Mem. in Opp. at 4 et seq.) Neither side provides the Court with any authority as to whether the Pennsylvania choice of law provision extends to how this Court should interpret an ERISA document – an inquiry that falls squarely within the purview of federal law. However, the Court need not decide this issue for apparently neither Circuit has decided the question of whether an ASA is a plan document for these purposes.

The Third Circuit has recently held that "anti-assignment clauses in ERISA-governed health insurance plans as a general matter are enforceable." *Am. Orthopedic & Sports Medicine v. Independence Blue Cross Blue Shield*, 890 F.3d 445, 453 (3d Cir. 2018). Likewise, the Second Circuit has held that "an assignment is ineffectual if the [ERISA benefit] plan contains an unambiguous anti-assignment provision." *McCulloch Orthopaedic Surgical Svcs., PLLC v. Aetna Inc.*, 857 F.3d 141, 147 (2d Cir. 2017) (quoting *Physicians Multispecialty Grp. v. Health Care Plan of Horton Homes, Inc.*, 371 F.3d 1291, 1295 (11th Cir. 2004)) (internal quotation marks omitted). However, neither the Second nor the Third Circuit has decided whether an ASA is a "Plan Document" under ERISA such that an anti-assignment provision in an ASA would be binding on Plan participants. Accordingly, the Court looks elsewhere for guidance.

For ERISA-purposes, a plan document "is one which a plan participant could read to determine his or her rights or obligations under the plan" and not one that merely "memoralize[s] the obligations [the administrator] and Defendant Company owed to each other." *Local 56, United Food and Commercial Workers Union v. Campbell Soup Co.*, 898 F. Supp. 1118, 1136 (D.N.J. 1995); *Askew v. R.L. Reppert Inc.*, 2016 WL 447050 (E.D. Pa. Feb. 5, 2016) *aff'd*, 721 F. App'x 177 (3d Cir. 2017) (quoting the same); *see also Normann v. Amphenol Corp.*, 956 F. Supp. 158, 162 (N.D.N.Y. 1997) (quoting *Curtiss-Wright Corp. v. Schoonejongen*, 115 S. Ct. 1223, 1230 (1995); 29 U.S.C. § 1102(a)(1) & (b)4(4)) ("ERISA requires that '[e]very employee benefit plan . . . be established and maintained pursuant to a written instrument' and 'specify the basis on which payments are made . . . from the plan.'[] The purpose of the written documents requirement is to allow an employee 'on examining the plan documents, [to] determine exactly what his rights and obligations are under the plan'")).

The Seventh Circuit has directly considered the question at bar and decided that an "ASA is not a 'plan document' for purposes of holdings its terms against a plan participant or beneficiary." *Fritcher v. Health Care Service Corp.*, 301 F.3d 811, 817 (7th Cir. 2002) (citing *Local 56*, 898 F. Supp. at 1136). The First Circuit has also considered whether the Court could look to an ASA to cure ambiguity, and found that "[a]ny terms that concern the relationship between the claims administrator and the beneficiaries cannot be held against the beneficiaries where, as here, the terms appear in a financing arrangement between the employer and the claims administrator that was never seasonably disseminated to the beneficiaries against whom enforcement is sought." *Stephanie C. v. Blue Cross Blue Shield of Mass. HMO Blue, Inc.*, 813 F.3d 420, 429 (1st Cir. 2016) (citing *Fritcher*, 301 F.3d at 817).

Other district courts across the country have similarly found that an ASA or ASA-type agreement is not a plan document. *See, e.g.*, *Miller v. PNC Financial Svcs. Group, Inc.*, 278 F. Supp.. 3d 1333, 1350 (S.D. Fl. 2017) (citing *Fritcher* for the assertion that an ASA is not a plan document and therefore could not constitute a grant of discretion); *Erlandson v. Liberty Life Assur. Co. of Boston*, 320 F. Supp. 2d 501, 509 (N.D. Tex. 2004) (explaining that an administrative services contract that was not provided to plan participants could not, "therefore, be considered a part of an ERISA plan"); *Mirick v. Prudential Ins. Co. of Am.*, 100 F. Supp. 3d 1094, 1097 (W.D. Wash. 2015) (An "ASA [is] generally not considered part of the ERISA plan"); *Rada v. Cox Enterprises, Inc.*, 2012 WL 3262867, at *4 (D. Nev. Aug. 7, 2012) ("Aetna contends that its termination should be reviewed under an abuse of discretion standard because of language in the Administrative Services Contract between Aetna and [the employer] conferring discretionary power upon Aetna. . . . The Administrative Services Contract cited to by Aetna is not part of the plan, integrated or otherwise, and is not distributed to employees. It does

not confer discretionary authority on Aetna for reviewing Plaintiff's claims"); *Trustees of Colorado Laborers Health & Welfare Trust Fund v. Am. Ben. Plan. Adm'rs, Inc.*, 2006 WL 2632308, at *5 (D. Colo. Sept. 13, 2006) ("While Defendant is named as a 'fiduciary' in the ASA, such an administrative services agreement is not a 'plan instrument.' A plan instrument is a written document that establishes and maintains an ERISA plan. *See* ERISA § 403(a)(1) . . . In the present case, two plan instruments exist: the original Trust Agreement and the Restated Plan Document. Significantly, Defendant is not named as a fiduciary in either instrument. . . . Based on the evidence presented, the court rejects Plaintiffs unsupported assertion that Defendant is a 'named fiduciary' under ERISA § 402(a)") (internal citations omitted); *L & W Associates Welfare Ben. Plan v. Estate of Wines ex rel. Wines*, 2014 WL 117349, at *8 (E.D. Mich. Jan. 13, 2014) ("The Court rejects the Estates' suggestion that the [Administrative Services Contract ("ASC")] is the underlying ERISA plan document. The ASC is a contract between BCBSM [the claims administrator] and L & W that governs the relationship between those parties. It contains no benefit-defining language, does nothing to apprise plan participants of their benefits or rights under the Plan and is not a Plan document"); *Briscoe v. Preferred Health Plan, Inc.*, 2008 WL 4146381, at *3 (W.D. Ky. Sept. 3, 2008) ("[T]he Plaintiffs urge, we think correctly, that the Administrative Services Agreement which was entered into between [the employer] and [the claims administrator] for the management of the Plan is not a Plan Document. It is a private contract between the employer and its third-party administrator"); *Wimmer v. Hewlett-Packard Co.*, 2009 WL 10670689, at *3 (N.D. Ga. Apr. 21, 2009) (discussing the disclosure of documents during discovery and noting in dicta that "the ASA is not a standard ERISA plan document insofar as it does not establish or delineate the rights of the Plan beneficiaries; it merely defines the contractual relationship between [the employer] and [the claims administrator]"). Reading

these cases together, there appears to be a consensus that an ASA is not an ERISA plan document and, therefore, a Plan beneficiary is not bound by its terms.

Here, Defendants insist that the anti-assignment clause in the ASA prohibits the Patient from assigning her rights under the Plan even though there is no such clause in the SPD, or presumably in any other ERISA Plan document based on Defendants' failure to demonstrate otherwise. Defendants cite to two cases in the Third Circuit that have upheld anti-assignment provisions, but they are readily distinguishable as the relevant provisions are not solely memorialized in ASAs. *See Lehigh Valley Hosp. v. UAW Local 259 Social Security Dep't.*, 1999 WL 600539, at *3 (E.D. Pa. Aug. 10, 1999) (upholding an anti-assignment provision in a plan document); *Atlantic Spinal Care v. Highmark Blue Shield,* 2013 WL 3354433, at *2 (D.N.J. July 2, 2013) (dismissing an action in which the patient assigned her rights where "the applicable health benefits plan contains a clear anti-assignment provision"). Accordingly, the Court rejects Defendants' argument and finds—as so many other courts have—that the ASA is not an ERISA document and is not binding on the Patient.

II. Rule 12(b)(1) Motion to Denied

A. Rule 12(b)(1) Legal Standard

A case may properly be dismissed for lack of subject matter jurisdiction pursuant to Rule 12(b)(1) "when the district court lacks the statutory or constitutional power to adjudicate it." *Makarova v. United States*, 201 F.3d 110, 113 (2d Cir.2000). "In contrast to the standard for a motion to dismiss for failure to state a claim under Rule 12(b)(6), a 'plaintiff asserting subject matter jurisdiction has the burden of proving by a preponderance of the evidence that it exists.'" *MacPherson v. State St. Bank & Trust Co.*, 452 F. Supp. 2d 133, 136 (E.D.N.Y. 2006) (quoting *Reserve Solutions Inc. v. Vernaglia*, 438 F. Supp. 2d 280, 286 (S.D.N.Y. 2006)), *aff'd*, 273 F.

App'x 61 (2d Cir. 2008); *accord Tomaino v. United States*, 2010 WL 1005896, at *1 (E.D.N.Y. Mar. 16, 2010). "In resolving a motion to dismiss for lack of subject matter jurisdiction, the Court may consider affidavits and other materials beyond the pleadings to resolve jurisdictional questions." *Cunningham v. Bank of New York Mellon, N.A.*, 2015 WL 4101839, * 1 (E.D.N.Y. July 8, 2015) (citing *Morrison v. Nat'l Australia Bank, Ltd.*, 547 F.3d 167, 170 (2d Cir. 2008)).

B. The Motion to Dismiss Pursuant to Rule 12(b)(1) is Denied

Defendants argue that the Court should dismiss this action pursuant to Rule 12(b)(1) because Plaintiff lacks standing to bring this suit in light of the ASA's anti-assignment provision. The Court has already found that this anti-assignment provision is not binding on the Patient. Thus, when the Patient assigned her rights to Plaintiff, Plaintiff was vested with standing to bring the instant action. As such, Defendants' motion to dismiss pursuant to Rule 12(b)(1) is denied.

III. Rule 12(b)(6) Motion to Dismiss

Defendants state in their introduction to their Memorandum in Support that they also move to dismiss pursuant to Rule 12(b)(6). However, Rule 12(b)(6) is never mentioned again in either their Memorandum in Support or in their Reply Memorandum in Further Support, and they do not advance any arguments in support of such motion. As Defendants abandoned their motion to dismiss pursuant to Rule 12(b)(6), it is denied.

CONCLUSION

For the foregoing reasons, Defendants' motion to dismiss pursuant to Rule 12(b)(1) and Rule 12(b)(6) is denied in its entirety.

SO ORDERED.
Dated: Central Islip, New York
March 20, 2019

/s/
Denis R. Hurley
United States District Judge

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
----------X
LONG ISLAND NEUROSURGICAL ASSOCIATES, P.C.,

Plaintiff,

Civil Action No.:
2:18-cv-00081-DRH-AYS

-against-

HIGHMARK BLUE SHIELD and REED SMITH LLP,

Defendants.
----------X

AMENDED COMPLAINT

By way of this Complaint, and to the best of its knowledge, information and belief, formed upon a reasonable inquiry under the circumstances, Plaintiff, Long Island Neurosurgical Associates, P.C. ("LINA"), brings this action against Defendants, Highmark Blue Shield ("Highmark"), and Reed Smith LLP (the "Employer"). The Employer sponsors the Group Benefits Program under which Emily Marmo, Highmark ID Number RDM120491146001 ("Emily"), a patient of Plaintiff LINA, received health care coverage, and, upon information and belief, is a self-funded Plan (meaning it paid the costs of health care for employees out of its own assets). Upon information and belief, the Employer is the Plan Administrator. Highmark is the Claims Administrator and Third-Party Administrator ("TPA") for the Employer.

1. This is an action under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and its governing regulations, concerning Highmark's under-reimbursement of LINA for surgical services involving: (i) a bilateral frontotemporal parietal craniotomy for craniofacial repair of multiple sutural synostosis including bilateral coronal sutures, sagittal sutures, and metopic suture, (ii) autologous bone cranioplasty for reconstruction of skull defect

greater than 5 centimeters, a very difficult procedure; and (iii) right and left myocutaneous transfer and suspension of temporalis muscles with bilateral myocutaneous flaps.

2. The patient, Emily, a 4-year old girl, born on July 2, 2012, had her first craniofacial reconstruction in 2012. Given her expected growth and disease process, her cranial sutures continued to close prematurely, requiring this second stage operation. This defect, left untreated, causes severe facial deformity, orbital crowding, and craniocephalic disproportion. This places her at risk for visual disturbance, developmental delay, secondary chiari malformation, headaches, and neurologic impairment.

3. Emily was admitted to Cohen Children's Medical Center in New Hyde Park, New York (the "Hospital") on or about January 12, 2016 with multisultural synostosis and worsening cranial deformity.

4. Steven J. Schneider, M.D. (Dr. Schneider"), a physician of Plaintiff, examined Emily and determined that she required surgery to treat her condition.

5. Dr. Schneider, Emily's physician, was one of the only pediatric neurosurgeons with privileges at the Hospital who could perform this complex surgery. The only other pediatric neurosurgeons with privileges at the Hospital who could perform this surgery are also physicians of LINA.

6. Dr. Schneider is an officer of LINA and is a pediatric neurosurgeon with extensive specialty training in the field of pediatric neurosurgery.

7. Dr. Schneider graduated from Baylor College of Medicine where he also did his residency. He did his fellowship in pediatric neurosurgery at New York University School of Medicine. He is board certified by the American Board of Neurological Surgery and the Pediatric Board of Neurological Surgery. He is co-chief of pediatric neurosurgery at Cohen's

Children's Medical Center and a clinical assistant professor at Hofstra University School of Medicine.

JURISDICTION

8. The Court has subject matter jurisdiction over LINA's ERISA claims under 28 U.S.C. § 1331 (federal question jurisdiction).

9. The Court has personal jurisdiction over the parties because LINA submits to the jurisdiction of this Court, and each Defendant, Highmark and Employer, systematically and continuously conducts business in the State of New York, and otherwise has minimum contacts with the State of New York sufficient to establish personal jurisdiction over each of them.

10. Venue is appropriately laid in this District under 28 U.S.C. § 1391 because (a) Highmark resides, is found, has an agent, and transacts business in the Eastern District, (b) Highmark conducts a substantial amount of business in the Eastern District, including marketing, advertising and selling insurance products, and insures and administers group healthcare insurance plans both inside and outside the Eastern District, including from offices located in the Eastern District, and (c) upon information and belief, the Employer transacts business in the Eastern District.

PARTIES

11. Plaintiff LINA is a professional corporation with offices at 410 Lakeville Road, Suite 204, New Hyde Park, New York 11042. It is engaged in the practice of neurosurgery, including pediatric neurosurgery.

12. Defendant Highmark Blue Shield is a health care insurance company with offices located in Pittsburgh, Pennsylvania and offers Highmark-branded health care insurance in the State of New York and contiguous counties.

13. Defendant Reed Smith LLP has a self-funded plan providing health care insurance benefits to its employees. Upon information and belief it is administered by a benefits department within its company who function as the Plan Administrator and the Plan Sponsor. It has offices in New York, New York.

14. Upon information and belief, Emily's plan has a Summary Plan Description ("SPD") that provides the benefits department sole and absolute discretion to administer, apply, and interpret the Plan established by the Employer and to decide all matters arising in connection with the operation or administration of the Plan. Without limiting the generality of the foregoing, the Employer and/or its duly authorized designees, including the Appeals Committee with regard to benefit claim appeals, have the sole and absolute discretionary authority to: take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan.

FACTUAL ALLEGATIONS

15. On January 12, 2016, Emily, a patient of Dr, Schneider and a beneficiary of the Employer, underwent surgery for a bilateral frontotemporal parietal craniotomy.

16. Dr. Schneider performed the surgery on January 12, 2016 at the Hospital.

17. After the surgery, for the medical services rendered on January 12, 2016, LINA submitted an invoice under: (i) CPT Code 21175 with modifier 80 in the amount of $24,166.50, but Highmark allowed only $888.23 thereof; (ii) CPT Code 15732 (2 units at $16,500 each) in the total amount of $33,000.00, but Highmark allowed only $2,461.10 thereof; and (iii) CPT Code 61559 with a modifier 22 in the amount of $66,000.00, but Highmark allowed only $5,489.70 thereof.

18. The modifiers 22 and 80 indicate that it was a complex, difficult, risky surgical procedure.

19. The total amount billed was $123,166.50; the total amount allowed was only $8,839.03. Emily's co-insurance and deductible totaled $3,780.32, resulting in a total payment to LINA of $5,088.71.

20. Highmark's explanation of benefits ("EOB") dated February 29, 2016 stated that LINA was out of network and that Emily was responsible for the amount not covered. It reinforced that it provides the administrative claims services only and advised LINA to refer to the benefit booklet or agreement which it never provided to LINA despite LINA's requests therefor.

21. LINA's billing company, Business Dynamics ("BD"), filed several appeals to Highmark. In the First Appeal dated April 7, 2016, BD stated that the reimbursement rates are based on the usual and customary treatment charges for the specialty and the geographic region where the treatment was provided. It further stated that the payment received does not appear to be comparable to rates charged for this service locally and no information was given to support that the reduction from the amount billed was correct. BD requested that the reductions be reversed and that Highmark submit the applicable policy language which justifies the reduction as well as the data used to establish the reimbursement rate.

22. Highmark denied LINA's request for additional reimbursement and did not provide the documentation requested.

23. On October 7, 2016, BD sent a Second Level Appeal and reiterated that Highmark failed to document the applicable fee schedule and to present the policy guidelines supporting the payment method. BD also wrote that it confirmed that the claims should have been processed based on what is acceptable throughout the nation, which is the 80th percentile of FairHealth.

BD included the benchmarks for Highmark's review and requested that the claim be reprocessed and that the appeal be reviewed by a qualified professional.

24. Highmark denied BD's Second Level Appeal in a letter to BD dated October 17, 2016. Once again, Highmark failed to document the applicable fee schedule and to present the policy guidelines supporting the payment method. BD again made the same requests to Highmark that were included in the letter dated October 7, 2016.

25. Highmark sent a letter to BD dated January 6, 2017 indicating that the patient was only entitled to two levels of appeal and that since the two levels of appeal were received on July 12, 2016 and September 21, 2016, all appeals were exhausted. It added that Highmark could not therefore review BD's request for an additional appeal and that under ERISA, providers are not able to file an appeal on behalf of a patient without consent. However, Emily's parents did sign the appropriate documentation and same was never requested prior to this letter. Nevertheless, LINA did provide such consent to Highmark. As for the pricing for services, Highmark stated that when covered services are provided outside of the geographic area by non-participating providers, the plan allowance is based upon the prices established by the local Highmark licensee. That suggests that Highmark, as TPA of the Employer, established the rates, but it did not provide guidelines or the SPD. As such, LINA contends that the reimbursement rates were arbitrary and unreasonable.

26. Dr. Schneider sent a letter explaining the surgery to Highmark. In a response letter dated February 21, 2017 to Dr. Schneider, Highmark stated that the claim was reviewed and that the additional information submitted by Dr. Schneider did not substantiate the complexity or necessity for extended time to warrant additional reimbursement for CPT Code 61559 22. However, no justification was provided for this conclusion of Highmark.

27. In all denial letters from Highmark, Highmark insisted that the claims were processed correctly. However, there was no explanation as to the rationale for how the processing was made or the terms of the SPD Highmark purportedly followed.

28. On April 15, 2017, LINA's outside counsel sent an appeal letter to Highmark requesting that it reprocess the claim. Highmark responded on December 4, 2017 that the claim was "processed correctly in accordance with the non contracted provider allowance established under the member's benefits agreement," but it did not provide a copy of that agreement as previously requested by BD. It further stated that the member had exhausted both levels of appeals and had exhausted its remedies for additional reimbursement.

29. The SPD governing Emily's plan was never provided and Highmark cannot therefore justify Highmark's reimbursement of out-of-network providers based on the "member's benefits agreement." The "allowed amount" is presumably defined in the SPD for an out-of-network provider as "based on the Employer's payment rate of allowed charges to a network provider."

30. This response from Highmark is therefore ambiguous, arbitrary and not in accordance with the SPD.

31. For in-network providers, the allowed amount is presumably "in accordance with the member's benefits agreement," but that agreement was not provided to BD. Moreover, not all in-network providers have the same agreements and, therefore, not all providers have the same fee agreements.

32. Since the "in-network rate" is not a fixed or known rate, the SPD's definition of the "member's benefits agreement" to an out-of-network provider is subject to ambiguity. It cannot be said that the amounts Highmark paid to LINA are the proper rates set out in the SPD or that the reimbursement to LINA was accurate.

33. At a minimum, to establish a proper amount under the "member's benefits agreement," Highmark must base it on what it contractually paid other in-network pediatric neurosurgeons with qualifications equal to or better than Dr. Schneider. These qualifications include board certifications, specialty training, outcome success, and hospital privileges. If Highmark were to find that it had no in-network pediatric neurosurgeon meeting these qualifications, it should pay at the billed amount because it has no in-network rate to pay.

34. Because Dr. Schneider was the only pediatric neurosurgeon with privileges at the Hospital who could perform the complex surgery that Emily required (other than two other surgeons at LINA), including any in-network neurosurgeon, Highmark should have defined Dr. Schneider as in-network provider and paid him at an in-network rate, if such a rate could be determined, or at full billed charges where, as here, it could not legitimately determine an in-network rate.

35. Highmark does not have any pediatric neurosurgeons in its network not only with Dr. Schneider's expertise to perform this surgery and privileges at the Hospital, but anywhere in Nassau County at all. Emily could not have had this surgery performed by a Highmark in-network pediatric neurosurgeon because there were none in Highmark's network in the entire County.

36. This is not surprising. There are only three pediatric neurosurgeons in Nassau County who can perform this complex pediatric neurosurgery, and all are associated with LINA. The procedural codes for which LINA billed Highmark are considered some of the most complex codes in pediatric neurosurgery.

37. Based on the above, and consistent with the terms of the SPD, Plaintiff should have been paid the in-network rate or, alternatively, the billed amount.

38. This is entirely consistent with NY Ins. Law § 4804(a), which states:

> **Access to Specialty Care**
>
> If an insurer offering a managed care product determines that it does not have a health care provider in the in-network benefits portion of its network with appropriate training and experience to meet the particular health care needs of an insured, the insurer shall make a referral to an appropriate provider, pursuant to a treatment plan approved by the insurer in consultation with the primary care provider, the non-participating provider and the insured or the insured's designee, at no additional cost to the insured beyond what the insured would otherwise pay for services received within the network.

39. LINA was the insured's designee. Highmark should have determined that it did not have an appropriate provider in its network and made a referral to the only appropriate provider, Dr. Schneider. It should have paid LINA the in-network rate for these procedures, which would have resulted in Emily incurring no additional costs other than the co-pay and deductible an insured would be liable to pay for in-network services.

40. NY Ins. Law § 4804(a) is consistent with the terms of the SPD and does not impose additional or inconsistent terms. Accordingly, it is not preempted by ERISA.

41. Alternatively, Highmark should have offered Plaintiff a Single Case Agreement. Such an agreement is common among insurers and out-of-network providers where the insurer does not have a provider in its network which can provide the required procedures or services for its member. It is a one-time agreement negotiated with the provider and does not encompass services beyond that provided to the single member. As such, it is a negotiated exception to the rates set out in the SPD governing out-of-network reimbursement.

42. Highmark also violated ERISA when it gave incorrect, unreasonable and invalid purported reasons for its under-reimbursements in its EOB and failed to provide any reason for its determination in its appeal response.

43. 29 C.F.R. § 2560.503-1(g) provides as follows:

Manner and content of notification of benefit determination.

(1) The plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520 2520.104b-1(c)(1)(i), (iii), and (iv). 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;

(v) In the case of an adverse benefit determination by a group health plan -

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.

44. Highmark provided none of the information required by 29 C.F.R. § 2560.5031(g), in violation of ERISA and the rules promulgated thereunder.

45. LINA received an Assignment of Insurance Benefits from Emily's parent and an Appointment as Authorized Representative. It states in relevant part:

Assignment of Insurance Benefits—Appointment as Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to Long Island Neurosurgical Associates, P.C. and their affiliated revenue management firm

(collectively, hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- File medical claims, appeals and grievances with the health plan
- File appeals and grievances with the health plan
- Institute any necessary litigation and/or complaints against my health plan naming me as plaintiff in such lawsuits and actions if necessary . . .
- Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan

Emily further designated LINA as his Authorized Representative under 29 C.F.R. § 2560.5031(b)(4).

46. LINA exhausted its administrative remedies. Upon information and belief, the SPD requires two levels of appeals, both of which were made and denied.

COUNT I

CLAIM AGAINST HIGHMARK FOR UNPAID BENEFITS UNDER EMPLOYEE BENEFIT PLAN GOVERNED BY ERISA

47. As the claims administrator for the Employer, Highmark is obligated to pay benefits to participants, beneficiaries and their assignees in accordance to the terms of the Plan, and in accordance with ERISA.

48. Highmark violated its legal obligations under this ERISA-governed plan when it under-reimbursed LINA for the pediatric neurosurgical services it provided to Emily, an Employer beneficiary, in violation of the terms of the SPD and therefore in violation of ERISA § 502(a)(l)(B), 29 U.S.C. § 1132(a)(l)(B).

49. LINA seeks unpaid benefits, prompt pay interest, and statutory interest back to the date LINA's claim was originally submitted to Highmark. It also seeks attorneys' fees, costs, prejudgment interest and other appropriate relief against Highmark.

COUNT II

CLAIM AGAINST REED SMITH LLC, FOR UNPAID BENEFITS UNDER EMPLOYEE BENEFIT PLAN GOVERNED BY ERISA

50. As the Plan Administrator and Plan Sponsor for the Plan, the Employer is obligated to pay benefits to Employer Plan participants, beneficiaries and their assignees in accordance to the terms of the Plan, and in accordance with ERISA. The Employer violated its legal obligations under this ERISA-governed plan when, through its Third-Party Administrator, Highmark, it under-reimbursed LINA for the surgical services in provided to Emily, a beneficiary of Employer, allegedly in violation of the terms of the SPD and therefore in violation of ERISA § 502(a)(l)(B), 29 U.S.C. § 1132(a)(l)(B).

51. LINA seeks unpaid benefits, prompt pay interest, and statutory interest back to the date LINA's claim was originally submitted. It also seeks attorneys' fees, costs, prejudgment interest and other appropriate relief against the Employer.

WHEREFORE, LINA demands judgment in its favor against Highmark and Reed Smith LLP as follows:

(a) Ordering Highmark and Reed Smith LLP to recalculate and issue unpaid benefits to LINA;

(b) Awarding LINA the costs and disbursements of this action, including reasonable attorneys' fees, costs and expenses in amounts to be determined by the Court;

(c) Awarding prompt pay interest;

(d) Awarding prejudgment interest; and

(e) Granting such other and further relief as is just and proper.

Dated: February 28, 2018

NAN GEIST FABER, P.C.

By: /s/ Nan Geist Faber
Attorney for Plaintiff
Long Island Neurosurgical Associates, P.C.
996 Dartmouth Lane
Woodmere, NY 11598
T. (516) 526-2456
nfaber@nangeistfaber.com

cc: Counsel of Record (via ECF)

AO 440 (Rev. 06/12) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

Eastern District of New York

LONG ISLAND NEUROSURGICAL ASSOCIATES, P.C.,

Plaintiff(s)

v.

HIGHMARK BLUE SHEILD AND REED SMITH LLP,

Defendant(s)

Civil Action No. 2:18-cv-00081-DRH-AYS

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)*

REED SMITH LLP
599 Lexington Avenue
29th Floor
New York, NY 10022

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

Nan Geist Faber, Esq.
NAN GEIST FABER, P.C.
996 Dartmouth Lane
Woodmere, NY 11598
(516) 526-2456

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

DOUGLAS C. PALMER
CLERK OF COURT

Date: 02/28/2018

Signature of Clerk or Deputy Clerk

Civil Action No. 2:18-cv-00081-DRH-AYS

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____

was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____

_____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____

_____ , a person of suitable age and discretion who resides there,

on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is

designated by law to accept service of process on behalf of *(name of organization)* _____

_____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify)*:

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____

Server's signature

_____

Printed name and title

_____

Server's address

Additional information regarding attempted service, etc: