SUPERIOR COURT OF NEW JERSEY

CIVIL LAW DIVISION
ESSEX VICINAGE

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Re: Sutter v. Horizon Blue Cross/Blue Shield of NJ
Docket No. L-3685-02

Dear Counsel:

The court has before it a motion by a plaintiff for class certification. This court previously issued an opinion dated February 13, 2003 which, in principal part, denied defendant's motion to dismiss, but did grant defendant's motion to dismiss those claims which emanated out of the New Jersey Consumer Fraud Act. The opinion also held that plaintiff's claims for payment for services to participants in the Federal Employee Health Benefit Program were preempted by the for Federal Employee Health Benefit Act, and the plaintiff's claims under the Federal M & C Program would be dismissed for failure to comply with administrative procedures. Subsequent to the issuance of this court's February 13, 2003 opinion, counsel have spent more than one year engaged in extensive discovery on the class certification issue. Rather than to restate the factual background to this motion, the court will refer to pages 1 to 3 of its February 13, 2003 opinion, except where discovery has disclosed additional facts.

I. The Appropriate Legal Standard

The pertinent Rule regarding class actions is R. 4:32-1 which reads as follows:

Requirements for Maintaining Class Action

(a) General Prerequisites to a Class Action. One or more members of a class may sue or be sued as representative parties on behalf of all only if (1) the class is **so numerous** that joinder of all members is impracticable, (2) there are questions of **law or fact common to the class,** (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) **the representative parties will fairly and adequately protect the interests of the class.**

(b) Class Actions Maintainable. An action may be maintained as a class action if the prerequisites of paragraph (a) are satisfied, and in addition:
(1) the prosecution of separate actions by of against individual members of the class would create a risk either of (A) inconsistent or varying adjudications with respect to individual members of the class which would establish incompatible standards of conduct for the party opposing the class, or (B) adjudications with respect to individual members of the class which would as a practical matter be dispositive of the interests of the other members not parties to the adjudications or substantially impair or impede their ability to protect their interests; or
(2) the party opposing the class has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole; or
(3) the court finds that the **questions of law or fact common to the members of the class predominate over any questions affecting only individual members,** and that a **class action is superior to other available methods** for the fair and efficient adjudication of the controversy. The factors pertinent to the finds include: first, the interest of members of the class in individually controlling the prosecution or defense of separate actions; second the extent and nature of any litigation concerning the controversy already commenced by or against members of the class; third, the difficulties likely to be encountered in the management of a class action.

II. The Prompt Payment Claims

As set out in page 2 of the court's February 13, 2003 opinion, there are two new Jersey Statutes, N.J.S.A. 17B:26-9.1, known as the HINT Act, and N.J.S.A. 17B:30-32, known as the Prompt Payment Act, which compel health care payers to promptly pay providers. For purposes of this opinion, the Acts will be referred to as the prompt payment laws. This court has previously determined that the prompt payment laws allow for private causes of actions. The remaining issue, then, is whether those private causes of action may be asserted in a class action.

Counsel have agreed that such a class would consist here of slightly more than 40,000 physicians and physician groups.

A very similar matter has already been addressed by another New Jersey Superior Court Judge. In Zakheim v. Amerihealth HMO Inc., Docket No. L-6235-00, Judge Ronald Freeman in Camden County discussed whether a prompt payment class action on behalf of physicians could be properly certified. The relevant portions of his oral opinion bear repeating:

> These obligations include one that AmeriHealth process and respond to every physician claim within 30 days of receipt.
>
> And two, that AmeriHealth response in one or two ways, either by payment of the claim, or notification to the physician of any perceived deficiencies in the claim which cause it not to be deemed a complete claim.
>
> In response to an incomplete claim, a physician can either dispute the finding - - dispute the finding or correct and resubmit the claim.
>
> Plaintiff claim that AmeriHealth has routinely and systematically failed to comply with the clear and material timeliness of response provisions in the standardize contract.
>
> This failure, in their opinion, constitutes a beach of contract that has resulted in and continues to result in substantial injury to plaintiffs and other physicians, members of the proposed class, and improper financial benefit to AmeriHealth......
>
> Now, Bruce Zakheim and Dr. Michael J. Conrad are physicians licensed to and practicing medicine in the State. These physicians also entered - - entered into a standardized contract with AmeriHealth.
>
> Now, the proposed class plaintiffs seek to represent, in this matter, is made up of thousands of New Jersey physicians who either, one, prior to July 1995, entered into an standardized contract with Keystone or its predecessor, which standardized contract imposes specific time limits to respond to claims for payment ....[1]
>
> In or about July 1st of 1995, or since July of 1995, entered into a standardized contract directly with AmeriHealth, imposing specific time limits for AmeriHealth to respond to claims for payment for - - and they were injured - - were injured since at least July of 1995 by AmeriHealth's breach of these standard contract provisions by failing to timely respond to timely submitted claims to that class.

[1] The prompt pay laws did not go into effect until July 1999, which explains why Judge Freeman was addressing contractual, not statutory, claims.

Now, the four requirements that must be met for a class to be certified are, one, numerosity; tow, commonality; three, typicality; and four, adequacy of representation - - representatives.

.... I'm satisfied that the class is so **numerous** that joinder of all members would, therefore, be impossible. This class involves any healthcare provider who entered into a standardized contract with AmeriHealth, formerly Keystone, since 1995.

So with respect to the issue regarding **numerosity**, I am satisfied that that requirement has, indeed, been met.

With respect to the issue or the requirement of **commonality**, I'm satisfied that the underlying issues, in this case, are common to all members of the class, as to whether AmeriHealth breached its standardized contract with physicians by failing to respond to a substantial percentage of claims for compensation within the 30 day period required by those contracts.

Now, more - - with respect to the issue of **typicality**, I'm satisfied that the representative parties are typical in the class. The claims arise from the same operative facts as those of other physicians who have suffered damages as a result of the defendant, AmeriHealth's failure, to respond to claims, in a timely manner, as required by their own standardized contract.

The named - - the plaintiffs do not assert any unique legal claim or theories different from those of other potential claim members - - class members. The claims of all potential claims members arise from the course of conduct on the part of the defendant, AmeriHealth, failing to timely respond to the claims.

The defendants have not demonstrated that the difference among potential class members would place the interest of the claims class in a significant jeopardy.

Moving on to the **adequacy of representation**, I've had a chance to review the documents or the moving papers. And I'm satisfied that both the lawyers who represented the class and the individuals designated a class representative must be scrutinized under the adequacy prong.....

If any - - if after vigorous scrutiny in the prerequisites of 4:31-1A are met, I'm satisfied and I also had a chance to review, <u>In re Manage Care Litigation</u> (phonetic). That's cited at 209 FD – FRD 678, a Florida, 2002 case. I've read that and I'm satisfied that, in this court's opinion, that the class would be adequately represented properly.

Now, **common questions of law and fact, in this court's opinion, indeed, do predominate**. This Acton arises out of the defendant's systematic failure to respond to claims for compensation submitted by members of the class within the time frames prescribed in defendant's standardized contract.

The question under this prong is whether the potential class, including absent members, seek to remedy a common legal grievance. And I cite , In re Cadillac, 93 New Jersey Supreme Court 412, 1983.

In the instant litigation, individual claims would require every class member to prove the existence of alleged identical activities of the defendant to prove liability. These claims arise out of form contracts which is particularly appropriate for class actions.

The logic here is that the class - - the contracts are uniform. The same principles of interpretation apply to each contract. That all members of the class share a common interest in the interpretation of an agreement to which each is a party.

I am satisfied that common questions of law and fact are predominant among the class in the instant case.

With respect to **class action superior** to other methods for resolving this controversy, it's this Court's opinion that the breach of contracts, in the instant matter, inflict economic injury in large member - - if large numbers of individuals had to incur the expense of pursuing individual claims, further economic detriment would be suffered.

Also, the numerous amounts of suits that would be filed would create inefficient and inconsistent administration of justice.

And for these reasons, pursuant to Rule 4:32-1A, et cetera, et als, 4:32-1B3, this Court is satisfied....[2] (See Transcript of Oral Argument of Zakheim vs. Amerihealth HMO, INC., Motion for Class Certification, pp. 88-96.)

Before addressing Zacheim the court will note that at the July 19, 2004 oral argument herein, all counsel agreed that four generally separate class action certification issues - - commonality, typicality, predominance of common factual and legal issues, and manageability - - all revolve around the exact same question in this case.[3] That is, if it does not require individual examination to determine if each physician is owed money, plaintiff may prevail on **all** of the above tests, but if it does require individual examination to determine if each physician is owed money, defendant may prevail on **all** of the above tests. For that reason, both in this

[2] Counsel informed the court that the Appellate Division has not reviewed Judge Freeman's opinion.

[3] The only caveat to this sentence is one proffered by Horizon: it claims that at least on the non prompt pay issues Dr. Sutter's claim may not be "typical". As set out in Point IV, footnote 9, of this opinion, the court was not persuaded that Dr. Sutter's practice is atypical of pediatricians who have contracted with Horizon. On the other hand, the issue of whether **any** pediatrician could present a typical fact pattern similar to the issues of a 40,000 member 55 specialty class implicates the commonality, predominance, and manageability requirements. As will be set out below, the answer is no.

section and in each of the succeeding sections of this opinion, the concepts of commonality, typicality, predominance and manageability will be discussed together, unless the circumstances otherwise dictate. The court is organizing its opinion this way even though it is aware that in other cases, there may be significant differences in how a court should address these factors.

There are three obvious differences between this case and Zacheim. First, Zakheim involved a physician only class, while the case under consideration originally included "medical practices, hospitals and related entities". (Amended Complaint ¶4) Dr. Sutter has now modified his prospective class to include only physicians and physician groups. (Supplemental Answer to Interrogatory No. 14). Thus, there is no difference in that area between this case and Zakheim.

The second difference between Zakheim and this case on the prompt pay class certification issue is that both the lead plaintiff and his counsel differ, which could lead to a different result on the adequacy of representation test. Nevertheless, defendant makes no claim that Dr. Sutter is unrepresentative of the proposed class on prompt payment issues. The only real attack defendant makes on the representative quality of Dr. Sutter's practice is that his "coding pattern is egregiously dissimilar to that of other pediatricians". (Brief, p. 44). That argument is addressed, and disposed of, in Point IV, footnote 9, of this opinion. Similarly, there is no claim that the proposed plaintiff's class counsel, Nagel, Rice, Dreifuss & Mazie, would not adequately represent the class, either because of lack of competence and experience, or conflicts.

The third difference between Zakheim and this case on the prompt payment class issue is that plaintiff herein seeks to include all physicians, regardless of the contractual relationships to defendant, while Zakheim only involved physicians who had a contractual relationship with defendant. The difference is apparently due to the timing of the two lawsuits, with Zakheim encompassing the pre HINT and Prompt Payment Act era and this case encompassing the Statutory era. As Dr. Sutter explains in his reply brief: "[Prompt pay law] is statutory, and [it is]

not disputed that the law is applied uniformly to all physicians regardless of their network status." (See Plaintiff Reply Brief, page 8, footnote n. 4) Dr. Sutter is correct; there is no reason that a prompt pay class should not apply to all physicians, whether or not in the network.

This court can see no reason, therefore, not to follow Zakheim. Indeed, with only minimal exaggeration, Dr. Sutter stated in his reply brief:

> In fact, in its 53-page opposition brief, Horizon devotes only a few paragraphs to the prompt pay issue, obviously recognizing that the uniform application of the HINT Act and Prompt Payment Act to all physicians is both common and typical and thus suitable for class treatment. (See Plaintiff's Reply Brief, Pg. 1)

In its supplemental brief, Horizon makes a sophisticated, and somewhat ingenious expanded argument against certification of the prompt pay class. It begins with the assertion that some class members may be owed **more** than a nominal sum:

> Dr. Sutter's position is that the amount of money likely to be due to each of the members of the class alleged under this category of claim are too small to make it economically worthwhile for any of them to bring an action to recover those sums. Dr. Sutter, however, has not presented **any evidence** reasonably suggesting that this is the likely fact. To the contrary, it appears more likely than not that the opposite conclusion would be a reasonable assumption. Dr. Sutter has represented on several occasions that he believe the amounts of interest due to class members by Horizon for its improper late payments may amount to "eight figure".
>
> The smallest "eight figure" number is Ten Million Dollars ($10,000,000). Assuming a maximum class size of thirty thousand members, the "average" amount due to a class member would be Three Hundred Thirty Three Dollars ($333.00). This amount is very likely too low as there is no evidence that all the providers who submitted claims to Horizon have suffered a prompt payment injury. To the contrary, Prof. Wiggins's data based empirical analysis proves that the overwhelming majority of claims were paid by Horizon within thirty days. This supports the conclusion that the average amount due to that minority of providers would be **much higher**.
>
> Assuming that some class members are due interest, it is completely improbably that each of them would be owed the same amount of interest by Horizon. The standard distribution pattern- i.e. the range of amounts owed t such class members – would be a bell shaped curve in which the class members on the left hand side of the curve might be owed amounts ranging from nothing at all to a few dollars, while members at the right hand end of the curve could be owed many thousands of dollars. Indeed, it seems highly probable that there would be at least a few large provider groups who have contracts with Horizon who would be owed some **very large sums** of interest if Horizon were engage in violations of the prompt pay law on the scale suggested by Dr. Waters. Because Dr. Sutter offered no evidence that the distribution is other than that predicted by a normative bell curve, he failed to provide this court with any objective basis upon which to conclude

> that there are no class members, or even too few class members, who have sufficient dollars at stake to warrant seeking judicial relief on an individual basis for prompt pay claims. (See Defendant's Supplemental Brief in Opposition to Class Certification, Pg. 3)

Horizon goes on to argue that the variability of the 40,000 claims -- including the possibility that some physicians may be owed "nothing at all to a few dollars" and others "many thousands of dollars" precludes the class from being certifiable under the reasoning of In re Merrill Lynch Securities Litigation, 191 F.R.D. 391 (D.N.J. 1999), aff'd 259 F. 3d 154 (3d Cir. 2001). In that case Judge Debevoise denied certification of a class composed of customers of a broker dealer which allegedly violated its duties to execute trades on the basis of the National Best Bid and Offer price and also failed to "cross" customer orders. He held that the "most critical" consideration weighing against class certification was "that whether a class member suffered damages would have to be determined on a trade by trade basis". Id. at 396. The Third Circuit affirmed, essentially on Judge Debevoise's reasoning.

The court is not persuaded that Merrill Lynch is controlling. First, the holding of Merrill Lynch has not been extended beyond securities actions. See, e.g., Bissette v. Avco Financial Services, Inc., 279 B.R. 442, 452 (D.R.I. 2002) (rejecting defendant's Merrill Lynch arguments because of the "heightened requirement of proof of harm for individual [securities fraud] claims ..."). Second, New Jersey courts have not generally adopted Merrill Lynch's holding. Horizon can only point to a smattering of Federal Court decisions in New York, Virginia and Texas doing so. The recent decision in Muise v GPU Inc. (App. Div. 2004) cites Merrill Lynch approvingly, but did not, in main, allow de-certification of the class action. One reason New Jersey is reluctant to deny class certification in this area is explained by Fulco and Williams "Class Actions un New Jersey State Courts, 24 Rutgers L.J. 737 (1993):

> There are a number of differences between the New Jersey and federal class action rules; two are of major importance. First, the fluid recovery provision is the most significant. With fluid recovery, the persons who receive the benefit do not necessarily have to be the people harmed or defrauded by the defendant's conduct. The court uses cy pres theories

to distribute any monies obtained to people in circumstances similar to those subject to the harm, i.e., the same "class" of people.(See 24 Rutgers L.J. 737 at 745)

. . . .

New Jersey courts have taken a very liberal stance on certification of class actions. (See 24 Rutgers L.J. 737 at 746)

. . . .

Care must be taken to focus on the differences in New Jersey's rule when evaluating the persuasiveness of federal precedent. (See 24 Rutgers L.J. 737 at 746)

. . . .

The Law Division has also noted that, in some respects, the requirements for class certification in New Jersey are even less demanding than those imposed by the federal rules, after which Rule 4:32-1 was modeled: "Indeed, the amendments to R. 4:32-2(b) and (c), effective April 1, 1975, evidence a clear desire by our Supreme Court that certain hurdles which have impeded federal class actions be removed in this state." New-Jersey courts have recognized that "[t]he judicial economy inherent in the efficient resolution of multiple party disputes is the cornerstone of the class action suit." (See 24 Rutgers L.J. 737 at 747).

In addition, as Dr. Sutter points out, there are much less serious proof problems herein than in Merrill Lynch, since the one most likely proof problem herein - - an argument that payments to certain doctors were late because the doctors submitted "unclean" claims which delayed payment - - cannot be made as Horizon has submitted no proof that it ever fulfilled the Statutory requirement to timely inform a single New Jersey physician to request specific information. The contrast with Merrill Lynch is extraordinary. As the United States Court of Appeals for the Third Circuit pointed out six times in finding that Judge Debevoise did not abuse his discretion:

Examining millions of trades to ascertain whether or not there was injury meant that individual issues overwhelmed common questions among the class, said the [District] Court, 259 F.3d at 187.

. . . .

Whether a class member suffered economic loss from a given securities transaction would require proof of the circumstances surrounding each trade, the available alternative prices and the state of mind of each investor at the time the trade was

requested. This Herculean task, involving hundreds of millions of transactions, counsels against finding predominance. (emphasis added) Id. at 187.

. . . .

The alleged injuries in Newton (the lead plaintiff's name) arise out of the execution of hundreds of millions of trades, not a single act of fraudulent conduct. The distinct facts among the hundreds of thousands of plaintiffs involving hundreds of millions of trades will determine whether securities violations occurred. Id. at 187.

. . . .

The distinct facts among the hundreds of thousands of plaintiffs involving hundreds of millions of trades will determine whether securities violations occurred. Id. at 190.

....

Here there are hundreds of millions of transactions executed over several years. Id. at 191.

....

With hundreds of millions of trades, it is difficult to imagine how this case can be tried. Id. at 191.

....

In contrast to Merrill Lynch, no "state of mind" analysis is needed herein; it would certainly not require "Hercules" to do the simple arithmetic in computing the late payments and the interest thereon in this case. Any competent accountant, special master or attorney could perform that ministerial task.

One additional reason this court will allow the class is that the court has before it information not before Judge Freeman: a statistical analysis of Horizon's prompt payment compliance (or, rather, non compliance) by Teresa Waters, Ph.D., as well as a Market Conduct Examination of Horizon by the Department of Banking and Insurance ("DOBI"), addressing the same subject. Both documents provide plausible statistical analysis - - Dr. Waters' analyses being the more exhaustive - - of Horizon's failure to adhere to the prompt pay laws.

At the risk of over-simplifying, the DOBI'S study began from the bottom up; that is, the Department studied individual files, found errors, and extrapolated. Then the DOBI studied larger number of denied claims and found similar error ratios in terms of failure to promptly pay. Dr. Waters' analysis may more accurately be described as top down. She divided total medical

expenditures by 365 (366 in a leap year) to find Horizon's average daily medial expenditures; divided the year-end claims payable balance by the average claim to find out how many days of expenditures were sitting in claims payable; and used that number to estimate the number of days it takes Horizon to pay a claim on the average. After eliminating an estimated number of "unclean claims", Dr. Waters calculated the average number of days claim payments were overdue versus the prompt pay law and then multiplied by 10% (the New Jersey Statutory rate) to arrive at the appropriate damages. While this court cannot now hold that these analysis are sufficient either procedurally or substantively to prove plaintiff's case, these studies certainly evidence a real likelihood that Dr. Sutter's case on prompt pay will be manageable as that term is used in Rule 4:32-1.

Horizon's two experts, Ruthann Russo and Steven Wiggins, Ph.D. submitted 20 and 31 pages reports, respectively. The reports were primarily denoted to rebutting Dr. Waters' non-prompt pay analysis; one page of the Russo report and approximately seven and one half pages of the Wiggins's report are devoted to prompt pay issues. Their principal **prompt pay** arguments are that (a) some prompt pay failure may have been caused by unclean claims (which is a difficult argument in some respects because N.J.A.C. 11:22-1.6 requires prompt notification to the provider of the reasons for a dispute or denial, and Horizon has provided no such proof); (b) Waters' analysis is too "high level" or aggregate; (c) some class numbers could be over compensated and some under compensated under Waters' calculations; and (d) their analysis is more accurate than hers. All this may be true, but it is not sufficient to demonstrate unmanageability. (Horizon does not dispute the DOBI'S methodology.)

Plaintiff is helped on the issue by the recent decision in Muise v. GPU, Inc. In Muise the Appellate Division found that even though damages on behalf of 100,000 consumers had to be proven individually, this should not preclude certification (or, more accurately, compel de-

certification). In that case, where customers brought a class action against electric utility in connection with power outages arising from high demand during a week-long heatwave, Judge King held, "The proof or disproof of damages in individual case should be feasible through the use of customer claim forms and surveys, judicious use of interrogatories and demands for admission, reasonable investigative efforts, and perhaps statistical interpretation of sampling data from the relevant universe, established based on competent data."

In Muise, Judge King addressed the difficult question of whether to allow a class action when it was not certain that each individual member suffered damages. He wrote:

> Here, it might be reasonable to presume that all class members, merely by losing power, suffered some damage, if only the inconvenience of having to reset clocks. Even so, departure from the general preference for individualized proof would be warranted only if plaintiffs provided a reliable mathematical formula for calculating aggregate damages.

Applying Judge King's holding to the prompt pay class, Horizon could argue that the possibility some class members may be owed "nothing at all to a few dollars" precludes certification. But the court has before it (a) the unrebutted DOBI report that shows fairly extensive prompt pay violations, using a random sampling methodology; (b) Dr. Waters' analysis which shows Horizon's average days to pay claims to be so far above the 30 to 40 day Statutory requirements (in no year was it less than 60 days) that it is highly unlikely many (or any) physicians were never victimized; (c) Dr. Waters' analysis which shows a "greater than" 40 days payment record which is so high (in no year less than 72%) that it is quite unlikely many (or any) physicians were never victimized; (d) no proof by Horizon that it ever notified a physician of an "unclean" claim; and (e) an 8 year period (the bulk of it occurring after the prompt pay laws were passed) in which the average physician filed 2500 claims. Taking all this into account, the possibility that any but a handful of the 40,000 physicians are owed nothing is

obviously statistically close to zero, and not nearly high enough to preclude class certification under Muise.[4]

Furthermore, the court's earlier opinion denying Horizon's motion to dismiss did not dismiss Dr. Sutter's Sixth Count, for unjust enrichment, nor any of Dr. Sutter's other state law causes of action beside the Common Fraud Act claim. If one assumes the DOBI may be correct that Horizon violated New Jersey's prompt pay laws, and that some remedy may be appropriate, a court must try to ascertain if a class action is a "superior" method to adjudicate the liability and damage issues that ensue. See Carroll v. Cellco Partnership, 313 N.J. Super. 488, 509-510 (App. Div. 1998). This court can envision no effective judicial mechanism other than a class action. As set out below in footnote 5, there is clearly no meaningful administrative mechanism. Tellingly, Horizon suggests no mechanism. The record before the court demonstrates **no superior method.**

The New Jersey Legislature has seen fit to enact two Statutes mandating prompt pay by organizations responsible for paying physicians. Given the relatively small amounts of money to which each physician may be entitled it is unlikely that many doctors would bring individual suits. A denial of class certification would make N.J.S.A. 17B:26-9.1 and 17B:30-32 virtually meaningless in a practical manner.[5] One doubts the Legislature would have desired such a result.

This conclusion is **not** based on Judge Moreno's decision in In re Managed Care Litig., 209 F.R.D. 678 (S.D. Fla. 2002). The court recognizes that Judge Moreno's decision could be

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[4] Assume 2,500 average physician's claims. Assume Dr. Waters is correct that 78% of all claims were paid after 40 days. The chance that any one physician was never paid late is 22^{2500} which is an infinitesimally small number. (The undersigned does not have available the computer resources necessary to make the exact calculation.) Even multiplying that number by 40,000 or lowering the 78% by a substantial amount, as Horizon's experts would prefer, does not lead to the likelihood one or more physicians were never paid late.

[5] As discussed on page 10 of the February 13, 2003 opinion of this court, the administrative remedy available to the DOBI is a $10,000 fine, a sum which pales in comparison to what plaintiff contends may be over $10,000,000 of interest lost by up to 40,000 physicians. Further, as is also noted on page 10, the DOBI has apparently never caused payers to pay back interest owed to physicians.

reversed by the United States Court of Appeals for the 11th Circuit. More importantly, this court believes that the prompt payment claims are the type of claims which, almost classically, meet the requirements of Rule 4:32-1.

See, for example, Varacallo v. Mass. Mut. Life Ins. Co., 332 N.J. Super 31 (App. Div. 2000) (where the court found sufficient commonality to support class action certification in a vanishing premium action against an insurer,); Strawn v. Canuso, 140 N.J. 43 (1995) (where 150 purchasers of new homes sued the home-builders and home-selling brokers for failing to disclose the existence of a nearby hazardous waste dumpsite.) Delgozzo v. Kenny, 266 N.J. Super. 169 (App. Div. 1993) (where the Appellate Division reversed the denial of class certification in a blue flame furnace case which had, the court believes, more typicality, commonality and manageability problems than Horizon can legitimately assert are present in Dr. Sutter's prompt pay class); In re Cadillac, 93 N.J. 412 (1983) (where the Supreme Court held that common questions of law and fact predominated and that a class action was the superior method of adjudication in consolidated actions against an automobile manufacturer in a statewide action on behalf of approximately 7,500 purchasers of automobiles with a certain engine problem,); Fiore v. Hudson County Employees Pension Commission, 151 N.J. Super. 524 (App. Div. 1977) (where the court found questions of law regarding interpretation of pension statutes common to all members of class,); Gallano v. Running, 139 N.J. Super. 239 (Law Div. 1976) (where court upheld a class action of 3,000 property owners who brought an action against the borough sewage authority and its counsel, alleging that the authority had improperly paid certain excessive legal fees,) and Lusky v. Capasso Bros, 118 N.J. Super. 369 (App. Div. 1972) (where court determined that claims by the citizens of the Village of Ridgewood, who sued defendants, in both tort and contract, for their wrongful discontinuance of garbage removal services, were typical, and class action was appropriate though computation of damages among members of

class would differ and there might be individual agreements which were not breached by licensees,).

III. The Downcoding, Bundling, and Refusal to Recognize Modifiers Class

In a rare spirit of accommodation, counsel have agreed that the downcoding, bundling, and refusal to recognize modifiers claims cannot be separated in a class action certification analysis. That is, counsel agree that, for example, there are no greater reasons to grant class certification to the downcoding claims than to the bundling claims. The court appreciates this mutual concession because common sense indicates it is true: all three claims are variations of one, which is that Horizon has systematically underpaid Dr. Sutter and other physicians.[6]

The court asked counsel if its decision on prompt pay class certification should lead it to more favorably consider granting certification of the non prompt pay class. The answer is no. Each issue must be separately analyzed. See Cannon v Cherry Hill Toyota, 184 F.R.D. 540, 544 (D.N.J.) ("This court has previously rejected the notion that class certification under Rule 23 is an 'all or nothing' proposition requiring class certification of all cause of actions asserted in a single pleading.")

A good starting point for analysis on this class certification dispute may be Judge Freeman's oral opinion in Malloy v. AmeriHealth HMO, Docket No. L-6235-00, a case consolidated with Zakheim. While the defendant in that case was not Horizon, the allegations were similar. For example, Dr. Sutter claims that defendant reduced "the amount of compensation paid to the plaintiffs for the medical services provided by intentionally altering the procedure code (CPT Code) to erroneously report a procedure of lesser complexity". Dr. Sutter claims that defendant uses standardized computer program including Claim Check to effectuate

[6] As a preliminary matter, the court should also note that Dr. Sutter has agreed to limit the class on these issues - - unlike the class on prompt pay - - to those physicians who signed network contracts with Horizon. Counsel informed the court that this will eliminate a few thousand class members, but have agreed the approximate number is still close to 40,000.

these underpayments. The Malloy plaintiffs made almost exactly the same allegation. Judge Freeman's holding is therefore instructive:

> The plaintiff entered into a contract with the defendant, AmeriHealth, to provide covered medical services to AmeriHealth insureds. The plaintiff and the class entered into a standard professional provider contract with the defendant, AmeriHealth HMOP, Inc., to become providers in the AmeriHealth network of physicians.
>
> The standard provider contracts obligate AmeriHealth to pay covered services rendered in AmeriHealth insureds by plaintiffs in the class in accordance with the reimbursement schedule which described covered services by appropriate current procedural terminology, those CPT codes.
>
> **Now, the plaintiffs allege that the defendant, AmeriHealth have unilaterally and systematically implemented a plan, using Claim Check computer software, to unlawfully reduce and delay the payment of these valid claims.**
>
> The proposed class plaintiffs seek to represent includes all medical providers who have entered into standardized provider agreements, here and after, the provider contracts, with the defendant since January of – January 1 of 1995 an whose payment for medical services rendered by systematically reduced or denied as a result of the defendant's application of a computerized cost containment program.
>
> . . . .
>
> With respect to the first prong, **numerosity**, I am satisfied that numerosity has been met. The class is so numerous that the joinder of all members would be impossible. This class involves any medical provider who entered into a provider contract with AmeriHealth.
>
> . . . On these issue regarding **commonality**, the Court is satisfied that under the issue common to all members of this class, in this matter, is whether AmeriHealth breached its provider contracts with physicians by failing to respond to substantial percentages of claims for compensation within - - with the period set forth in the reimbursement schedule incorporated in the standard provider contract.
>
> With respect to commonality, I'm satisfied that commonality has been met.
>
> On the issue with respect to **typicality**, it appears that the claims arise from the same operative facts as those of other physicians who have suffered damages as a result of the defendant AmeriHealth's failure to respond to claims in a timely manner, as required by the provider contract.
>
> The named plaintiffs do not assert any unique legal claim of theories different from those of other potential class members. The claims of all the potential claims members arise from the course of conduct on the part of the defendant, AmeriHealth failing to timely respond to the claims.

The defendants have not demonstrated, in this Court's opinion, the differences among potential class members in dealing with - - and I'm going to go back to this point. The Court had taken great consideration and concerns with respect to the Claim Check computer software program that is being used by the defendant, AmeriHealth.

It's this Court's opinion that the defendants have no demonstrated that the difference among potential class member will place the interest of the class in significant jeopardy.

With respect to **adequacy of representation**, I'm satisfied that both the lawyers representing the class and the individuals designated as class representative must be scrutinized under the adequacy prong.

And I'm satisfied that the scrutiny has been made and that they are qualified, experienced and are generally able to conduct the proposed litigation. And the named plaintiffs must and have no antagonistic opposition within the class.

The **common questions of law and fact predominate**. I'm satisfied that they do. This action arises out of defendant's systematic failure to respond to claims for compensation submitted by the members of the class within the time frames prescribed in the defendant's provider contract.[7]

The Court, once again, cites In re Cadillac, 93 New Jersey Supreme Court 412, 431, a 1983 case.

The Court is also looking at the **class action superior to other methods** for resolving this controversy.

It's this Court's opinion that breach of the contracts, in the instant matter, inflict economic injury if large numbers of individuals had to incur the expense of pursuing individual claims, further economic detriment would be suffered also - - would be suffered.

Also, the numerous amounts of suits - - lawsuits that would be filed would create inefficiency and inconsistency within the administration of justice.

I am satisfied that after perusal of the Rule 4:3201A, 4:30 - - 4:32-1B3, the Court will, therefore, rule and certify the class. (See Transcript Malloy vs. AmeriHealth HMO, Motion for Class Certification, Pgs. 97-101)

Of course, the court cannot disagree with Judge Freeman as to numerosity. In footnote 27, on page 25 of its Brief, Horizon grudgingly and guardedly makes this concession. Similarly, on the adequacy of representation issue, the court has already held that plaintiff's counsel can

[7] There are two mentions of "timelines" in Malloy, but the case primarily concerns bundling, downcoding, and refusal to recognize modifiers.

more than adequately represent the class. While Horizon argues that Dr. Sutter presents some differences in his downcoding issues (Defendant's Brief in Opposition to Class Certification, pp. 42-46) and bundling issues (Brief, p.14 and p. 25, footnote. 27) it cannot seriously argue against adequacy once Dr. Sutter agreed to remove non- network physicians from his class.

It is on the issues of commonality, typicality, predominance of common questions of law and fact, and manageability that the court believes Judge Freeman's analysis is not necessarily dispositive. In addressing these issues, the court will begin with commonality and typicality, starting with the differences between different medical specialties. To quote Horizon:

> **Providers in the proposed class differ widely by physician specialty with respect to how they utilize CPT codes and modifiers, thus defeating the requirements of commonality and typicality.** Different specialties use different modifiers, and when using the same modifiers do so at very different frequencies. Such differences vividly illustrate the variety and complexity of any proof that Horizon always improperly bundles and disregard modifiers across the full spectrum of providers in the class alleged. Dr. Sutter's own use of CPT codes is starkly at odds with that of other pediatricians . . . [There is a] wide disparity between the selection and frequency of Dr. Sutter's use of codes subject to bundling and modifier decision, and the use of such codes by other pediatricians and by other specialists. (See Defendant's Opposition Brief to Class Certification, Pg. 13.)
>
> Additionally, the coding practices of the proposed class of providers are inconsistent... **[There are] wide variation between different specialty groups** with respect to: a) the frequency with which different modifiers are presented on their claims, and b) the frequency with which such modifiers are paid or not paid by Horizon. [The] "RT" modifier [is] rarely... used by providers other than those involved in orthopedic surgery, ophthalmology and radiology.... the overwhelming users of ... modifier [si] are dermatologists. In contrast pediatricians are the clearly dominate users of modifier "21", while dermatologists barely register as users of that modifier. Significantly that far more often than not Horizon pays on the modifiers presented in the claims it receives. (See Defendant's Opposition Brief to Class Certification, Pg. 14)

Horizon also argues that, even putting aside difference in specialties, there are reasons that mitigate against a finding of commonality or typicality:

> In addition to coding issues, an enormous variety of possible factual combinations exist that can affect the outcomes of claims. The only way to determine whether Horizon's disposition of a particular claim is appropriate is to look at that claim individually. Dr. Water agreed, for example, that assuming Horizon had 100,000 bundling practices, i.e.

> edits, her methodology would require a review of the entire population of Horizon provider claims by a statistician and a coding expert. Ms. Russo has unequivocally opined that a claim by claim review is required. Such an undertaking is not feasible through a class action because of the overwhelming predominance of individual questions of fact affecting each claim by each provider. (See Defendant's Opposition Brief to Class Certification, Pg. 15)

Horizon further argues that even a major physician advocacy group, the AMA, has acknowledged that the proper coding of each claim is of utmost importance in winning what the AMA calls the "fight [against] bundling and downcoding". Further, Dr. Waters admitted that knowledge as to how class members coded their claims is critical to determining if the claims were properly paid. This is to be contrasted with the prompt pay claims which, except for the relatively insubstantial "non clean" claims defense, do not require the fact finder to examine the physicians' individual coding.

Both parties rely on their prompt pay experts - - Dr. Waters for plaintiff and Ms. Russo and Dr. Wiggins for defendant - - on the non prompt pay issues. Dr. Waters' methodology is based on a selection of random samples, a determination of how often downcoding, bundling, and refusal to recognize modifiers occurred, a determination of the rates of such "errors" in the categories wherein the errors most often occurred, a determination of the average dollar difference for each type of error, and, finally, a multiplication by the estimated number of such errors. (This is to be contrasted, of course, with her prompt pay methodology which did **not** use random sampling.)

Ms. Russo and Dr. Wiggins devote the bulk of their reports to rebutting Dr. Waters on the downcoding, bundling, and refusal to recognize modifiers issues. Ms. Russo points out that there is an ongoing battle between physicians and payors, with the former accusing the latter of "downcoding" and the later accusing the former of "upcoding". She cites data that Medicare loses $2 billion to $3 billion every year to upcoding. She further cites a recent search of the Office of Inspector General's website which revealed 93 articles on "upcoding by providers".

Not surprisingly, she contends that differences in specialties and individual practices make downcoding analysis too complex for Waters' formulations. On bundling, she contends physicians commonly engaged in "unbundling" and that the area is too complex to be calculated by Dr. Waters' formula. In regard to modifiers, she refers to a 290 page book entitled "Modifiers Made Easy" to conclude that modifiers claim must be addressed either individually or at least specialty by specialty, and not as proposed by Dr. Waters.

Dr. Wiggins takes a more academic approach. He argues that modern economic theory now incorporates the strong likelihood that contract players such as physicians will file erroneous claims, both because of legitimate errors (caused by the use of ordinary error free information) and illegitimate or strategic concerns. He quotes an American College of Cardiology consensus document as admitting that "Physicians may also be tempted to code 'aggressively' with inappropriate or unethical coding strategies."

Dr. Wiggins uses the analysis to argue that (a) Horizon has to employ the computer-driven methodology it does to detect intentional and unintentional error, and (b) the issues involved are too complex to be resolved in any other than a case-by-case manner. The first matter is not now before the court - - although the court notes that if Dr. Wiggins is correct that modern economic theory demonstrates that physicians may, for strategic reasons, tend to overcode, modern economic theory might presumably also demonstrate that payors such as Horizon would tend to undercode (unless Dr. Wiggins' theories of "basic economics... and common sense" apply only to physicians, and not insurance companies).[8]

[8] Horizon argues that (a) Dr. Wiggins' economic theories are more reliable than Dr. Waters' and, that (b) Dr. Waters is therefore guilty of promulgating "junk science," leading to the inevitable citation of the cases following Daubert v. Merrell Dow Pharm, Inc., 509 U.S. 579 (1993). The court could not agree less, since it is not aware of any scientific consensus favoring either Dr. Waters or Dr. Wiggins, and Dr. Waters appears to have impeccable academic credentials. Horizon elicited some admissions from Dr. Waters: she is not a coding expert or statistician (she is an economist) she never read the prompt pay laws "cover to cover", she knows that some courts do not accept random sampling of the type she did in her non prompt pay analysis, and she cannot name other analysists who have used her methodology in these type of cases. These admissions do not make her a purveyor of junk science.

It is Dr. Wiggins' argument that "assessment of the validity of claims is inherently an individual, claim-by-claim issue." Dr. Wiggins wrote as follows:

> To be concrete, consider Dr. Waters' proposed analysis of downcoding, though the arguments apply equally to bundling and unrecognized modifiers.
>
> As noted above, Dr. Waters' methodology rests on the assumption that the claim as filed is correct. Her proposed methodology then assumes that payment differences between the claim as filed an the claim as paid result from "bad behavior" by Horizon. Dr. Waters also does not propose a method for distinguishing between appropriate and inappropriate claims adjustment. In her methodology, all adjustments are presumed to be inappropriate without regard to actual facts. Dr. Water proposes, moreover, to (1) use average rates of alleged downcodes, and (2) only to focus on the more commonly downcoded CPT codes. Averaging will create diversity of economic interests within the proposed class for the reasons described above.
> Focusing on only certain CPT codes will create further diversity of interests. **There is substantial heterogeneity in the CPT codes used by various physicians. Part of this variation is associated with variation across specialty groups, and part of it is associated with variation across individual physicians even within a specialty.** The former occurs because different specialists undertake different medical procedures; surgeons perform different functions than pediatricians. The large differences in the CPT codes used by individual physicians are driven by (1) differences in background, local practice and medical training, (2) differences in patient populations and (3) differences in the accuracy of physician billing practices. Equally important, individual physicians, their staff or their third party billing entities vary in how accurately they report billing information. These differences will create differences in how often changes are required in the billing information submitted by physicians to Horizon's claims review process. Variation in the use of CPT codes and variation in the accuracy of claims filed will lead to conflicting interests among class members in Dr. Waters' proposed damage methodology.
>
> Perversely, physicians who use common CPT codes and CPT codes for which other physicians commonly make billing mistakes will garner a significant economic advantage from Dr. Waters' proposed damage methodology. If a physician accurately reports billing information together with appropriate documentation, the physician is much more likely to be paid appropriately. If that physician uses common CPT codes for which other physicians commonly make mistakes or do not supply appropriate information, claims adjustments for those other physicians using the same CPT codes are much more likely. The physician submitting the correct code, for which there was no adjustment, however, will be compensated by Dr. Waters' method in proportion to his use of that code. This compensation will be paid, moreover, even if in every single instance the physician timely received exactly the amount billed on his or her original claim.
>
> The same issues arise with the treatment of bundling and modifiers. Dr. Waters proposes to identify CPT codes that were "commonly" bundled or for which modifiers were not recognized. Physicians accurately submitting billing information for which they were paid timely in every single instance will be compensated along with those whose claims

> were bundled, or for which modifiers were not recognized. These problems create substantial diversity of interests within the proposed class in that compensable damages are not linked to actual injuries. **The only resolution of this issue is to investigate individual claims to determine whether they were downcoded, bundled or had unrecognized modifiers.**

Common sense indicates that Dr. Wiggins is at least partially correct: there is such a large number of possible coding combinations that the only **perfect** analysis would have to be claim by claim. On the other hand, our system cannot demand perfection. Horizon has admitted, for example, that a class action limited to a particular CPT Code or particular procedure is feasible, if not desirable. To some extent, the court is faced with a continuum: at one end is a class consisting of one CPT Code or one procedure, which would meet almost any test under R. 4:32-1, and at the other end is a class of every physician and every CPT Code or procedure, which may go too far. Section IV of this opinion may represent a reasonable solution to this problem.

On the interrelated commonality, typicality, predominance, and manageability issues, Dr. Sutter argues that Horizon's consistent use of certain software is dispositive:

> In fact, Horizon <u>admits</u> that it uses <u>standardized</u> computer programs including Claim Check, Code Review and its own internal modifier software to process claims submitted by physicians in order to <u>automatically</u> "bundle, downcode and otherwise reject inconsistently or improperly coded claims for service." (Opposition Brief at p.11). In other words, Horizon's use of these <u>uniform</u> computer programs to process the claims submitted by the physician class - - <u>regardless of the physician's specialty and the submitted CPT codes</u> - - and utilization of <u>exactly the same</u> automatic bundling, downcoding and modifier rules demonstrates why the class should be certified. (See Plaintiff's Reply Brief, Pg. 2)

The court disagrees. It believes that Horizon's analysis on this issue is persuasive:

> Dr. Sutter has not provided any evidence or logical explanation as to why Horizon's use of claims management software makes this case suitable for class treatment. Horizon's use of software to process claims has no relevance to the issue whether this case qualifies for class action status because the issue is not how Horizon manages the millions of provider claims it processes annually; it is whether each of the decisions about how much should be paid for each of those claims was proper. Thus Horizon's use of computer is irrelevant to the true issue in this case. (See Defendant's Opposition Brief, Pg. 22)

Horizon could hire several thousand more claims examiners instead of using computers and programmed software. It could train these examiners to apply the same coding, bundling, downcoding and regard for modifiers instructions as are programmed into the software. This shift in claims processing methodology, however, would not affect the issue whether a class action is the proper vehicle for the adjudication of the claims raised by Dr. Sutter's Amended Complaint. Under either methodology, the relevant issue for the Court remains whether it is possible to fairly and accurately determine whether Horizon has pad claims properly without looking at the particulars of those claims. In both settings, as the AMA, Dr. Wiggins and Ruthann Russo have made clear, the answer is "no". **The claim document, the patient's coverage status, Horizon's EOB, the medical records, and the particular medical justification for the service all are relevant and must be reviewed. Id.**

The most difficult hurdle for Dr. Sutter herein is that of manageability. The court disagrees with Dr. Sutter's ascertain that it should not examine manageability at this stage. It is true, as Dr. Sutter points out that Judge Wolin made a somewhat critical remark concerning an early pre-occupation with manageability problems in class actions. See In re Prudential Ins. Co. of America Sales Practice Litigation, 962 F. Supp. 450, 524-25 (D.N.J. 1997). But R. 4:32-1 could not be clearer. It requires a trial judge to evaluate "the difficulties likely to be encountered in the management of a class action."

This trial judge believes the difficulties in managing the non prompt pay claims of 40,000 doctors with different specialties would be extraordinarily severe. One way to demonstrate the difference in manageability between the prompt pay class and the non prompt pay class is to analyze Horizon's list of 12 items Dr. Sutter would have to prove to demonstrate liability on behalf of each of the class members. Horizon claims the proofs would have to include:

"a) the claim was paid late without proper interest;

b) two or more CPT codes were presented on the claim, but compensation improperly was paid only for one CPT code service;

c) the claim included a modifier to a CPT code which it is contended should have, but did not, result in a greater payment for the service identified by the CPT code; or

d) the claim included a modifier to a CPT code which it is contended should not have, but did, result in a reduced payment for the service identified by the CPT code (such as for co-surgeons);

e) the CPT code appearing on a claim was not the basis of the payment made by Horizon, and the payment was based upon a CPT code reflecting a lower level of service;

f) a capitation payment made by Horizon did not reflect all of the Horizon members who were registered on the class member's rolls;

g) that the provider timely filed an appeal of the improper payment made by Horizon;

h) the medical facts and records respecting the service provided justified the coding and modifiers submitted by the class member on the claim form to Horizon;

i) the distinct financial impact of Horizon's claims and capitation payment practices with respect to each class member's need to borrow funds that would not otherwise have been borrowed;

j) the distinct impact of Horizon's claims payment practices on each Class member that caused that individual to hire more staff, or incur greater administrative expenses;

k) the efforts and methods utilized by each class member to assure that the claims submitted for payment to Horizon were "clean claims" with the meaning of the State's Prompt pay statute; and

l) the means and methods utilized by each class member to keep accurate track of their claims submitted to Horizon and the payments received from Horizon." (Defendant's Supplemental Brief in Opposition, pp. 23-24)

The most interesting aspect of the list is that only (a) and (k) directly involved prompt pay claims. Of these items, (k) is a non issue because Horizon did not specifically advise any doctors of "non clean" claims problems. Put differently, almost all of Horizon's list of issues which might cause manageability problems involves the **non prompt pay claims.**

Horizon's explanation of its **defenses** demonstrates even more clearly the great manageability issues inherent in the non prompt pay claims:

> Horizon will present testimony detailing why it is necessary for it to utilize computerized claims processing systems. This subject likely will encompass the absolute necessity for processing systems that prevent improper payments for are not subject to coverage.. . . Horizon will document the huge amounts of coverage dollars that are lost to provider fraud and billing error in order to explain to the trier of fact why there have to be safeguards and

cautions built into any claims payment system, whether that system is computerized or manual in nature. . .

To establish the substantive fairness and propriety of its coding criteria about which Dr. Sutter complains, Horizon may delineate for the trier of fact the medical and policy rationale for all of the "code edits" in its claims adjudication system. This could include a detailed history of Horizon's communications with providers, medical societies and medical associations prior to and during the class period, respecting proposed coding decisions and choices.

To the extent that Dr. Sutter's claim is that no bundling is permissible, no modifiers can be disregarded and no downcoding is allowed irrespective of the facts disclosed on the claim or otherwise known to Horizon, Horizon may be required to demonstrate why each and every aspect of its claim edits is legitimate. In that connection, Horizon may be required, for example, to compare its edits to the more than 120,000 bundling edits the CMS CCI system implements.

With respect to damages component of the case, depending of occurs upon the nature of plaintiffs' attempted proofs, Horizon will be required to present detailed provider by provider analyses to demonstrate the arbitrary and unreliable nature of those proofs. At present, it appears very likely that if a class were certified, Horizon will seek to establish offsets against each and every class member exactly as if Dr. Sutter were the only plaintiff. Horizon may not be deprived of any of its due process rights as a defendant because a case is certified as a class action. (See Defendant's Supplemental Brief in Opposition, pp. 31-32)

With 40,000 class members, the defense would certainly create severe manageability problems for a **non prompt pay class**. In sum, whether analyzing the proofs Dr. Sutter may have to advance or the defenses Horizon may assert, the manageability problems inherent in a 55 specialty bundling, downcoding, and refusal to recognize modifiers case are quite serious.

Horizon also pointed out in an earlier brief that, without differentiating between plaintiff's proofs and defendant's proofs, there were at least **14 items** that needed to be proven win the non prompt pay portion of the case. (Brief, p. 37). The list dwarfs the proofs necessary in a prompt pay class.

Dr. Sutter does not agree that any of these proofs would be necessary, arguing that "the liability issue. . . would be tried as a battle of experts" (Supp. Brief, p.3, n.1). It may be premature to decide the issue, but there is a strong argument that if Dr. Sutter relied solely on Dr. Winter's statistical sampling and extrapolation on the non prompt pay issues, he would run afoul of Judge King's admonition in <u>Muise</u> against departing from "the generalized preference for

individualized proof". It would seem he would have to combine Dr. Waters' statistical sampling with the type of individualized data Judge King discussed at the conclusion of Muise: "claim forms and surveys, judicious use of interrogatories and demands for admission, reasonable investigative efforts . . ." Once Dr. Sutter moves to that level of proof, manageability problems become more serious.

There is no easy answer open to the court. The fact that Horizon uses certain software packages to initially evaluate all claims, regardless of specialty, is interesting but not dispositive. Nor is the fact that Horizon's software does not require, as a first cut, an analysis of the individual medical records of each claimant. As Dr. Wiggins points out, it is not possible to perform a task of such magnitude by beginning with individual records. Further, the somewhat non-individualized methodology Horizon uses to process claims is not necessarily an indication of the methodology a court may or should use to adjudicate claims. Due process may require that the court do more.

The court must weigh a variety of considerations, among which are the following:

1. The 55 disparate medical specialties sought to be included.
2. The differences in office coding procedures among different physicians even in the same specialties.
3. The possibility that a case by case or claim by claim analyses may be preferable is necessary in both liability and damage decisions (multiplied by the more than 100,000,000 decisions made on the claims by the 40,000 physicians during the 8 year period of time encompassed by this suit).
4. The concomitant truth that very few, if any, individual cases will ever be brought, owing to the cost of such suits.

5. The difficult manageability problems that arise from the lack of commonality and typicality of the claims.

As noted above, Muise could arguably provide some answers to the manageability problems of a mammoth non prompt pay class. But in Muise, the defendant's potential liability -- the power outage – was a single, somewhat easy to prove event, leading to manageability issues only on damages. Here there may well be 40,000 liability decisions even before one approaches the damage decisions. The case, as constituted, would be more difficult to manage as a class action than either Muise or the prompt pay case (although less difficult than Merrill Lynch).

Finally, there is one other major difference between the prompt pay and non prompt pay classes. Ms. Russo argues that some physicians, using Dr. Sutter as an example, have been paid more than they should have on certain bundling-unbundling disputes. See, for instance, her discussion of Dr. Sutter's claims for "a urinalysis that could have been bundled under an E & M visit code." She claims that this and similar matters occurred so frequently that slightly over $90,000 was involved. The court has no way of knowing if any of this is true, but does note that there may be a violation of Horizon's due process rights if it is not allowed to argue that some physicians are owed nothing either because they were never victimized or because of offsets. Obviously, the offset issue is irrelevant to the prompt pay class.

When one moves to the mandate set out in Carroll, supra, and In re Cadillac, supra to study alternative methods of adjudication of the non-pediatrician bundling, downcoding and refusal to recognize modified claims, the analysis is also not simple. One method discussed in Carroll is injunctive relief. The Amended Complaint herein does not specifically seek injunctive relief, but does ask for "such other relief as the court deems equitable and just". The analysis necessary to determine if Horizon wrongly uses Claim Check and other similar software to underpay on one or several procedures or codes (and the legal issues inherent in any injunctive action) would be

substantial, but not as substantial as the analysis necessary to determine which of 40,000 physicians may have been overpaid and, if so, by law much for each doctors. Limiting the non pediatrician bundling, downcoding and refusal to recognize modifiers part of the suit to injunctive relief would allow a type of "unjust enrichment" to Horizon if Horizon were found to have been utilizing improper methodology, but, as the Carroll and Cadillac courts pointed out, some wrongs may have to go without redress. The court will require further briefing on the issue of whether injunctive relief may be sought on behalf of this class or not. If it may, it would appear to be a "superior" method as that term is used in Rule 4:32-1(b).

On balance the court is concerned that the proposed class presents so many commonality, typicality, predominance, and manageability problems that a class action is not an appropriate mechanism, and certainly not a superior mechanism.

See Carroll v. Cellco Partnership, 313 N.J. Super. 488 (App. Div. 1998) (reversing class certification for purchasers of cellular phone services against vendors because individual misrepresentation claims required separate investigation,); and Saldana v. City of Camden, 225 N.J. Super. 188 (App. Div. 1991) (reversing an order of class certification because a class action was not the "superior" means of adjudication of the controversy, and the definition of the certified class was too nebulous.); K.P. v. Albanese, 204 N.J. Super 166 (App. Div. 1985) (declining to certify as a class action the challenge to a regulation governing mental health patient status on the ground that the individual patients needs varied, precluding a common fact question, and that the representative parties would not likely be typical of the claims and defenses of the entire class.); Romano v. Kimmelman, 96 N.J. 66 (1984) (holding a class action inappropriate for individuals, who were charged with operating motor vehicles while under influence of intoxicating liquor, from seeking injunctions against the use of test results of breathalyzers as evidence in drunk driving proceedings.); and see Doe v. Bridgeton Hospital

Ass'n, Inc., 71 N.J. 478 (1976) (where an action denominated as a class action was not maintainable as a class action where there has been no attempt to comply with the "maintainability" procedures of the rule,).

That this decision is not consistent with Judge Freeman's or Judge Moreno's is obvious. But there is no evidence that either Judge Freeman or Judge Moreno had before them the type of expert opinion and data available to this court. See In re Cadillac, supra, at 431 "...different courts, even when presented with substantially similar, if not identical, claims have reached divergent conclusions in deciding whether to certify a class action". That the decision is seemingly inconsistent with the decision on the prompt pay class does not concern the court because the prompt pay class presents far fewer typicality, commonality and manageability problems - - whether Horizon violated the prompt pay laws does not depend on the specialty of the physician involved, the procedure performed, the CPT Code, or the physician's coding practices.

IV. A Pediatrician Only Downcoding, Bundling, and Refusal to Recognize Modifiers Class

The issue, is close enough, however, that a pediatrician only class, in the court's opinion, **does** meet the requirements of R. 4:32-1. As to numerosity, counsel has informed the court that there are approximately 1,884 pediatricians that use Horizon. While that number is less than 40,000, it is more than sufficient to satisfy the numerosity requirement.

This brings the court to the interrelated questions of commonality, typicality, predominance, and manageability. Since all these issues were discussed previously, the court will adopt its earlier discussion, but shift the focus to pediatricians specifically, beginning with manageability. At the very minimum, a pediatrician only class would be 55 times more manageable than the class proposed by Dr. Sutter since there are 55 specialty groups which submit claims to Horizon (See Ms. Russo's report, page 8). It could also be considered approximately 15 times more

manageable, because there are approximately 15 times as many physicians in the entire class as there are pediatricians. The numbers 55 and 15 are almost certainly understated. As Dr. Wiggins points out "different specialists undertake different medical procedures; surgeons perform different functions than pediatricians", and as Ms. Russo points out "the reasons why an orthopedic surgeon would use modifier [ ] are **very different** from the reasons why a cardiologist or pediatrician could legitimately use [the same modifier]." As Ms. Russo continued, "because of the differences of claims submitted from physicians in different specialties an **extrapolation of findings across specialties** would be unreliable". See also the numerous color coded charts submitted by Horizon and Dr. Wiggins demonstrating that, in terms of bundling, and modifiers, there are vast differences between the specialties.[9] In sum, limiting the class to pediatricians tips the balance on commonality, typicality, predominance and manageability in an **exponential** fashion.

Neither party has argued for a pediatrician only class. To the contrary, Dr. Sutter argues that such a class would lead to judicial inefficiency because class actions on behalf of other specialties would then be filed. "The end result would be utter chaos with more than a dozen new and separate actions filed." (See Plaintiff's Supplemental Letter Brief, pg. 2). Perhaps. But even if this were true, it is also true that the current plaintiff class combines 55 specialties, many or most of which present different bundling, downcoding, and refusal to recognize modifiers issues since they physicians do different procedure and provide different services. A dozen

[9] Horizon's experts also tried to prove that Dr. Sutter's practice differs from that of many other pediatricians bringing into play questions as to "typicality" and "adequacy of representation". The court was not persuaded. Indeed, it is fairly certain that Dr. Wiggins and Ms. Russo could have "discovered" that any pediatrician in the State was atypical in his or her procedures, coding, etc..

separate lawsuits, whether or not consolidated for discovery and/or trials, would still be less unmanageable than the current plaintiff's class.[10]

A pediatrician only non prompt pay class also addresses the "generalized preference for individual damages" discussed by Judge King in Muise. As Horizon points out, a large percentage of pediatricians' claims are concentrated in very particular procedure codes. For example, just 10 procedure codes constitute 57.76% of pediatricians' bundled claim lines and 10 procedure codes (the highest two of which are also the highest two on the bundling list) constitute 26.01% of the claim lines submitted with a modifier. Discovery and trial should be able to identify if these and similar procedure codes are routinely and improperly subject to bundling, downcoding and refusal to recognize modifiers by Horizon. If not, defendant will presumably prevail. If so, it may well be possible to ascertain, with same statistical validity, the respective entitlement of the 1,884 pediatricians. Addressing the problem in these terms leads to the conclusion that a pediatrician only class action is a "superior" method under Rule 4:32-1(b).

V. The Capitation Class

The court noticed in the initial briefs a potential sub class, sometimes called the "capitation" class or sub class. Dr. Sutter described this class in his last brief and argued why it should be certified:

> The court requested additional information regarding Dr. Sutter's class capitation claim. This claim arises from Horizon's failure to immediately add patients to the capitation rolls of physicians upon their selection by the patients, and defendant's failure to pay interest no late paid capitation claims. . . certain physicians in the class are paid on a capitated basis, i.e., the physicians are paid a set dollar figure per month for all of their patients regardless of whether these patients actually seek treatment or not. In the course of her deposition, Horizon's provider relations representative, Anna Marie Sylvestro, testified that patients at the time of enrollment with defendant are asked to choose a primary care physician. The reason for this is to assign those patients to the chosen physician's capitation list.

[10] It is also possible that physicians in many other specialties do not experience enough bundling, downcoding, or refusal to recognize modifiers problems to justify a suit. Thus, it is possible the pediatrician only class will stand alone, or be forced by classes of only two or three other specialties. "Utter chaos" may be quite unlikely.

Q: Do you know what the policy is at Horizon is as to when a patient is first assigned to a physician's capitation list?

A: The member, when they're enrolling, is asked to choose a primary care physician at that time and at that time they are assigned to the members - - to the physician's capitation list.

* * *

When you actually showed up on the physician's capitation list, I'm not sure.

It is significant that Horizon cannot determine when patients actually first appear on the physicians' capitation rolls because it is undisputed that these physicians are not only entitled to the capitation payments immediately upon selection by the patients but, in addition, they are entitled to interest on capitation payments that should have been made to the doctors at the time they were first chosen. It is Horizon's regular business practice, however, not to compensate many physicians until the patient first sees the doctor for treatment. Particularly when these doctors are internists or other adult primary care providers, this can be a year or more after the patient first selects the doctor. The damages in this situation would be the capitation payments for that year as well as the interest on the last payments. Ms. Sylvestro conceded, however, that Horizon does not pay interest on retroactive capitation, assuming it even pay all of the retroactive capitation owed to the doctors:

Q: [W]hen [the patient] selects someone, the coverage is in effect, but that [patient] doesn't appear on the cap[itation] list [until a later date] the doctor would also get retroactive capitation in that instance, correct?

A: Yes.

* * *

Q: With respect to when retroactive capitation is paid, does Horizon pay interest on retroactive payments?

A: Not that I am aware of.

Although Dr. Sutter has yet to determine the precise number of physicians in the class that are paid on a capitated basis, we do know that Horizon converts its physicians from fee-for-service providers to capitated providers once 250 members are enrolled in the particular physician's practice. Ms. Sylvestro also testified that primary care physicians including pediatricians, family practitioners and internists are among those groups of physicians who are compensated in a capitated basis, which undoubtedly includes at a minimum hundreds if not thousands of physicians. Accordingly, the class should also be certified for this claim as well. (See Plaintiff's Supplemental Letter Brief, pp. 10-12.)

Horizon argues that there is not **sufficient evidence** to support this certification. In its rebuttal it states:

a) "Dr. Sutter provides **no evidence** Horizon failed to pay him capitation. . ."

b) "Nor did he provide **any evidence** . . . that the manner in which the capitation payments made to him were calculated . . . the same."

c) "Dr. Sutter provides **not even a scintilla of evidence** that improper deprivation of capitation payments by Horizon is an evidence problem. . ."

d) "Dr. Sutter presents **no evidence** that the amounts of improperly paid capitation are too small for any providers . . . to warrant . . . bringing an action agonists Horizon . . ."

e) "Dr. Sutter offers **no evidence** proving that, during the class period alleged, Horizon typically was timely informed by its members when they wished to be enrolled. . ."

f) "He provides **no evidence** either as to his own practice or as to the practices of his patients with whom he claims he did not receive timely capitation payments."

g) "Likewise, he provides **no evidence** as to the notification practices of any other putative class member." (See Defendant's Supplemental Brief in Opposition to Class Certification, pp. 13-17)

The **reason** both parties produced little evidence on this issue (or sub issue) is that the discovery was focused almost totally on the major issues: prompt pay, downcoding, bundling, and refusal to recognize modifiers. Counsel have informed the court that the capitation claims could encompass up to 3,000 numbers, but involves less money than the major claims. (Counsel agree that specialties which tend to see a limited number of patients and/or repeat patients - - neurosurgery, for example - - would virtually never have a member with a serious capitation claim.) The court could, theoretically, stay all proceedings in this case other than capitation discovery in the hopes that a perfect record could be achieved, but since the first class discovery

period in this case took over a year, the court is reluctant to do so. See R. 4:32-2(a) which requires as trial judge to make a certification decision "as soon as practical after the commencement of an action . . ."

Dr. Waters has produced a relatively straight forward approach to calculating damages on the capitation issue, primarily through use of Horizon's membership files. Her methodology is more direct and less reliant on sampling than her downcoding, bundling and refusal to recognize modifiers methodology. Neither Ms. Russo nor Dr. Wiggins analyzes or criticizes her methodology, although Horizon points out that her methodology (and plaintiff's ability to recover) hinges on Horizon learning that a patient has utilized a physician's service. Indeed, Horizon goes on to argue that once it is discovered that Horizon had not received the information in a timely fashion for many patients, the class would shrink dramatically in size. Horizon may have very strong defenses to the bulk of the capitation claims, but these defenses go to the merits- - they certainly do not implicate manageability problems since they merely involve the ministerial tasks of sending out notices and checking records.

There is at least a prima facie price argument that a capitation sub class meets the requirements of R. 4:32-1. There appears to be sufficient numerosity, adequate representation by Dr. Sutter since he is a pediatrician[11], and adequacy of representation by Dr. Sutter's counsel. The capitation issue presents questions of law and fact common to the class, and the claims and defenses of the representative parties present apparently typical questions of law and fact common to member of the class which predominate over questions affecting only identical members. A class action is not only manageable, but superior to other available methods for the adjudication of this controversy.

[11] As Horizon points out, there could be questions as to whether Dr. Sutter' individual situation makes him typical of pediatricians in terms of capitation, but this is not clear.

While made in a different context - - in support of his argument on certification of the non prompt pay class - - Dr. Sutter's citation of authority supporting class certification in borderline cases is instructive herein:

> New Jersey has long favored the granting of class action as a practical means to resolve common issues involving similarly situated claimants. The class action is "liberally construed", Carroll v. Cellco Partnership, 313 N.J. Super 488, 498 (App. Div.1988), and is "permitted unless there is a clear showing that it is inappropriate or improper". Lusky v. Capasso Bros., 118 .J. Super, 369, 373 (App. Div. 1972), certif. denied, 60 N.J. 466 (1972). Class certification should be granted unless "clearly infeasible". Riley v. New Rapids Carpet Ctr., 62 N.J. 218, 225 (1972). The "motion judge [is] required to give plaintiffs every favorable view of plaintiffs' complaint and the record." Varacallo v. Mass. Mut. Life Ins. Co., 332 N.J. Super. 31, 42 (App. Div. 2000) (citation omitted). In fact, **"[i]n a borderline case, the Court should allow class certification: 'the interests of justice require that in a doubtful case . . . any error, if there is to be one, should be committed in favor of allowing a class action."'** In re: Prudential Ins. Co. of America Sales Practices Litigation, 962 F. Supp 450, 508 (D.N.J. 1997) (citation omitted and emphasis added). (See Plaintiff's Supplemental letter Brief, Pg. 5.)

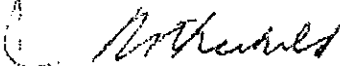
Unlike the prompt pay class and the non-prompt pay class issues, where there was enough discovery to allow the court to make a clear decision, the capitation dispute was not the subject of extensive discovery. In that context, and in light of what the court has learned about the capitation class, the above cases tend to support certification. As Judge King pointed out in Muise, however, if a judge has doubts about certification and later determines a class was not properly certified, he or she may decertify under R. 4:32-2(a). Like Judge Chaiet in Muise, this court is not "married to the concept of a class action" on capitation . . . and "will not hesitate to curtail this action . . . if the goals are not met."

VI. Conclusion

The Court grants Dr. Sutter's motion to certify the prompt payment class action for all New Jersey physicians. It will deny Dr. Sutter's motion to certify a class action for all New Jersey physicians on downcoding, bundling, and refusal to recognize modifiers. It will allow a class action on downcoding, bundling, and refusal to recognize modifiers for pediatricians only. It will certify the capitation class. As to New Jersey physicians who are not pediatricians, the

court will allow an application seeking injunctive relief only on downcoding, bundling, and refusal to recognize modifiers. Counsel should submit an appropriate order under Rule 4:32-2(d) which governs the conduct of partial class actions. Counsel are thanked for their diligent efforts on both sides. Because of them, the court believes it had more information available to it than the judges who handled similar matters previously.

Very truly yours,



JAMES S. ROTHSCHILD, JR., JSC

JSR:afc