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SUPREME COURT OF THE STATE OF NEW YORK — NEW YORK COUNTY

PRESENT: SALIANN SCARPULLA Justice

PART 19

Oxford Health Insurance

- v -

Jordan S. Josephson

INDEX NO. 602899/04

MOTION DATE

MOTION SEQ. NO. 013

MOTION CAL. NO.

The following papers, numbered 1 to _____ were read on this motion to/for _____

PAPERS NUMBERED

Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...

Answering Affidavits — Exhibits

Replying Affidavits

FILED
JUL 29 2010
COUNTY CLERK'S OFFICE
NEW YORK

Cross-Motion: ☐ Yes ☐ No

Upon the foregoing papers, it is ordered that this motion

decided per the memorandum decision dated 7/23/10
which disposes of motion sequence(s) no. 13, 15.

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE FOR THE FOLLOWING REASON(S):

Dated: 7/23/10

SALIANN SCARPULLA J.S.C.

Check one: FINAL DISPOSITION X NON-FINAL DISPOSITION

Check if appropriate: DO NOT POST

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: CIVIL TERM: PART 19

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OXFORD HEALTH INSURANCE, INC.,

Plaintiff,

-against-

JORDAN S. JOSEPHSON, M.D.,
JORDAN S. JOSEPHSON, M.D., P.C.,

Defendants.

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Index No.: 602899/04
Submission Date: 5/26/10
Motion Seq. Nos.: 013, 015

DECISION AND ORDER

JORDAN S. JOSEPHSON, M.D. and
JORDAN S. JOSEPHSON, M.D., P.C.,

Plaintiffs,

-against-

GEORGE LASTRA,

Defendant.

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Index No.: 106655/04

For Plaintiff:
Rivkin Radler LLP
926 Rexcorp Plaza
Uniondale, NY 11556

For Defendants:
Garfunkel, Wild & Travis, P.C.
111 Great Neck Road
Great Neck, NY 11021

HON. SALIANN SCARPULLA, J.:

Motions with the sequence numbers 013 and 015 are consolidated for disposition.

In this action to recover damages for fraud, unjust enrichment, and breach of contract, in motion sequence number 013, defendant Jordan S. Josephson, M.D. ("Josephson") moves for summary judgment dismissing the complaint.[1]

In motion sequence number 015, Oxford moves for summary judgment on its complaint.

Background

Oxford commenced this action on September 3, 2004. According to the allegations of the complaint, Oxford is a health insurer which provides health insurance coverage to its insureds, referred to as members. Oxford's point-of-service plans allow its members to use participating and non-participating providers.

Any Oxford member who uses non-participating providers and would like to get reimbursed from Oxford is subject to a deductible and coinsurance requirements. The member must first meet an annual deductible. Oxford will then reimburse the member a portion ("the Benefit"), which is either 70% or 80%, "of the lesser of either the UCR[2] for th[e] services [provided], or the Non-Participating Provider's actual billed charges. The Member is required to pay the balance of the Non-Participating Provider's bill as a Coinsurance payment."

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[1] Plaintiff Oxford Health Insurance, Inc. ("Oxford") cross-moved to amend its complaint to add Jordan S. Josephson, M.D., P.C. ("Josephson P.C.") as a defendant. At oral argument, held on September 23, 2008, the court (Lehner, J.) granted Oxford's request, and, on October 6, 2008, Oxford filed an amended verified complaint (the original and amended complaint are collectively referred to as the Complaint).

[2] UCR is the usual, customary, and reasonable charges for the particular health care services at issue.

A member may assign to a non-participating provider his or her right to payment from Oxford. The provider then submits a claim directly to Oxford, and Oxford pays the provider "whatever Benefit it is obligated to pay under the specific Insurance Documents for the Member at issue." Oxford alleges that deductible and coinsurance requirements were established in order to, among other purposes, "discourage excessive utilization of health care services, thereby reducing health care costs for . . . Oxford, its employer groups, and its Members."

The complaint further provides that Josephson, a New York State licensed otolaryngologist, is a non-participating provider. As such, he does not have a contract with Oxford that specifies his reimbursement fees. Oxford alleges that Josephson has submitted numerous claims forms to Oxford seeking reimbursement for performing endoscopic debridement procedures (the "Procedure"), CPT[3] Code 31237. Endoscopic debridement is performed "shortly after sinus surgery as part of post-operative care to reduce the possibility of residual or recurrent infection."

Oxford allegedly requires that a precertification be obtained before the Procedure is performed in order to determine the amount of the Benefit Oxford would pay a provider and the amount a member would be responsible to pay the provider. Failure to obtain precertification allegedly "significantly reduces any Benefit that

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[3] CPT stands for current procedural terminology, a coding system developed by the American Medical Association (AMA) and used by doctors and insurers to refer to services and procedures performed.

otherwise might be payable" to the provider. Josephson allegedly obtained precertification for the Procedure in some instances, and failed to do so in others.

Oxford maintains that "Josephson is by far the most frequent utilizer of code 31237 in Oxford's entire service area." Despite Josephson's representation that the Procedure was medically appropriate every time it was performed, Oxford alleges that he engaged in "gross overutilization of the Procedure," thereby inflating the cost of medical care to Oxford and its members.

In 2003, Oxford reviewed eight medical records of Josephson's Oxford patients who had undergone the Procedure and determined that reimbursement only for the first four Procedures per patient was appropriate. In support of its determination, Oxford cited a publication by the American Medical Association ("AMA") and an opinion of its internal ENT consultant, Oxford identified 54 of Josephson's patients, who between 1997 and 2002 had undergone more than four Procedures each. Josephson had been paid $213,045.00 for the excessive Procedures. Oxford demanded reimbursement of the $213,045.00 but Josephson refused.

On these facts, Oxford alleged four causes of action: (1) fraud; (2) declaratory judgment; (3) unjust enrichment; and (4) breach of contract. Oxford subsequently "withdrew any claims in the third and fourth causes of action where payment of an insured's claim was made by plaintiff more than six years prior to the commencement of the action." Accordingly, the causes of action for unjust enrichment and breach of

contract pertain only to payments which Oxford made to Josephson after September 1998.

Josephson asserted counterclaims against Oxford, which were dismissed pursuant to the court's order dated June 3, 2005 (Lehner, J.).

The Parties' Current Motions

Oxford and Josephson now each move for summary judgment. On September 23, 2008, the parties appeared for an oral argument before the court (Lehner, J.). Among other items, the parties addressed the issue of Josephson's alleged failure to produce billing and collection records. The court directed Josephson to produce all outstanding records, which he did. The parties also wanted to pursue settlement and requested that, in the interim, the court hold their pending motions in abeyance. In the end, settlement was not reached, and the parties sought the court's ruling on their motions.

The court (Lehner, J.) (1) permitted Josephson to use recently produced records at trial; (2) permitted Oxford to depose a Josephson witness regarding the recently produced billing records; and (3) permitted the parties to make supplemental submissions in support of their respective motions. Janice Cedeno, Josephson's billing manager, was deposed on November 3, 2009, and the parties then submitted supplemental affirmations in support of their respective motions.

The Scope of the Action

In the Complaint, Oxford alleged that this action pertains to 54 Members (the "54 Members") who underwent more than four Procedures each between January 1, 1997 and September 12, 2002. Oxford claimed that its overpayments total at least $213,045. In its Bill of Particulars dated December 14, 2004, Oxford alleged that this action pertains to 136 members.

In its motion, Oxford originally sought a judgment in the amount of $1,174,863.21 with respect to 86 members (the "86 Members"). In the alternative, Oxford sought $314,976.34 on its unjust enrichment claim, representing the amount by which Oxford allegedly overpaid Josephson as a result of his failure to collect the 86 Members' deductible and co-insurance obligations. The 86 Members were identified by their Oxford ID numbers in a chart (the "Geanuracos Chart") attached to an affidavit of Oxford's claim investigator Christine Geanuracos. Next to the patients' Oxford ID numbers, the Geanuracos Chart listed CPT codes of procedures/treatments that Josephson provided for the 86 Members. The Court notes that many CPT codes on the chart are not 31237.[4]

Finally, in its latest submission, Oxford represents that only 85 Members are at issue on its motion. Of the 85 Members, Oxford seeks summary judgment with respect to at least 26 Members (the "26 Members"), who allegedly did not pay anything to

[4] For example, with respect to patients whose ID numbers are 877410*03, 1652295*01, and 3096578*01, Oxford does not list any CPT 31237 Procedures.

Josephson for their treatment.[5] The other 59 Members (the "59 Members") allegedly paid only a small portion of their outstanding balances.

Discussion

To obtain summary judgment, a movant must tender evidentiary proof that would establish the movant's cause of action or defense sufficiently to warrant judgment in his or her favor as a matter of law. *Zuckerman v City of New York*, 49 N.Y.2d 557, 562 (1980). A motion for summary judgment must be denied if there is any doubt as to the existence of a triable issue of fact. *See Rotuba Extruders, Inc. v. Ceppos*, 46 N.Y.2d 223, 231 (1978).

A. Breach of Contract

The parties agree that Josephson, as an out-of-network provider, has no express contract with Oxford. Josephson's Oxford patients execute a form (the "Assignment Form"), pursuant to which they assign to him their rights under their policies to receive reimbursements from Oxford.

Oxford claims that as a result of the assignments, Josephson was bound by the terms of his patients' Oxford contracts. Josephson allegedly breached the contract "[b]y routinely performing excessive Procedures on the Members, over utilizing CPT code 31237, interfering with the benefit structure in the Insurance Documents, and inducing

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[5] Comparing the 26 Member list with the Geanuracos Chart, the Court notes that some of the 26 Members do not appear on the Geanuracos Chart as having underwent a CPT 31237 Procedure, including Robert J. (2314535*01), Dollert K. (877410*03), and Amy T. (36466910*01). Thus, it appears that in its final submission, Oxford has again changed the list of members/patients in question.

Members to be treated by him who would not have otherwise done so absent his representations."

It is axiomatic that a party claiming a breach of contract must show the existence of a valid contract between the parties. *See e.g. Furia v. Furia*, 116 A.D.2d 694, 695 (2nd Dept. 1986); *see also Sebro Packaging Corp. v. S.T.S. Indus., Inc.*, 93 A.D.2d 785, 785 (1st Dept. 1983).

In case of an assignment, an assignee "stands in the shoes" of an assignor and is in no better position than the assignor. *Long Is. Radiology v. Allstate Ins. Co.*, 36 A.D.3d 763, 765 (2nd Dept. 2007); *West Tremont Med. Diagnostic, P.C. v. GEICO Ins. Co.*, 13 Misc.3d 131(A) (App Term, 2d & 11th Jud Dists 2006). "[T]he assignee of rights under a bilateral contract does not become bound to perform the duties under that contract unless he expressly assumes to do so." *Sillman v. Twentieth Century-Fox Film Corp.*, 3 N.Y.2d 395, 402 (1957); *see also Amalgamated Tr. Union Local 1181, AFL-CIO v. City of New York*, 45 A.D.3d 788, 790 (2nd Dept. 2007)("an assignee . . . will not be bound to the terms of a contract absent an affirmative assumption of the duties under the contract"). Here, to prove that Josephson breached the Oxford contract, Oxford must show that Josephson has affirmatively assumed to be bound by the terms of his patients' Oxford contracts.

Oxford has failed to do so. Pursuant to the Assignment Form in question, Josephson is assigned only his patients' right to receive reimbursements from Oxford for his services. The Assignment Form does not provide that Josephson assumes any duties

of his patients under their Oxford policies. Accordingly, where reimbursement is unwarranted, Oxford may assert against Josephson the same defenses that it would have against its insured, such as lack of medical necessity or failure by the insureds to pay deductibles and co-insurance. *See e.g. Long Is. Radiology*, 36 A.D.3d at 765; *West Tremont Med. Diagnostic*, 13 Misc.3d at *3. However, Oxford may not claim that Josephson breached a contract, where he, as an assignee, has not affirmatively assumed any duties under his patients' Oxford policies. *See Sillman*, 3 N.Y.2d at 402; *Amalgamated Tr. Union Local 1181,* 45 A.D.3d at 790. Although Josephson himself claims that the assignments create an implied contract between him and Oxford, he does not argue, and has not shown, that he has assumed any duties under his patients' policies, such as, among other things, the duty to collect deductible and co-insurance payments. Accordingly, since there are no issues of fact as to the nature of Josephson's assignment, as a matter of law, the cause of action for breach of contract against him does not lie, and is dismissed.

B. Fraud

The elements of a cause of action for fraud require (1) a material misrepresentation of a fact, (2) knowledge of its falsity, (3) an intent to induce reliance, (4) justifiable reliance by the plaintiff, and (5) damages. *Eurycleia Partners, LP v. Seward & Kissel, LLP*, 12 N.Y.3d 553, 559 (2009).

Oxford alleges that Josephson made the following misrepresentations: (1) that he performed all of the Procedures in question, when he did not; (2) that all of the

Procedures that he did perform were medically necessary, when they were not; and (3) that he required his Oxford patients to pay in full their deductible and coinsurance obligations (the "Balance Payments") when he did not.

1. Procedure Performance

As to the alleged misrepresentation that he performed all of the Procedures for which he sought reimbursement, Josephson produces results of a survey (the "Survey") that Oxford itself conducted in 2002. Oxford surveyed those members who Josephson claimed had undergone the CPT 31237 Procedures between 1998 and 2002. The Survey asked them whether (1) they were treated by Josephson on the dates that he had represented to Oxford; (2) whether, and to what extent, he performed the Procedures on them; and (3) whether, as a result of treatment, they incurred any financial obligation to Josephson. The Members surveyed responded that they, in fact, had been seen by Josephson on the dates that he had represented to Oxford (*see e.g. id.* at OHP JOS 11237, 11241, 11244, 11246, 11247, 11258, 11262). Accordingly, Josephson has made a prima facie showing that he rendered the Procedures on the dates that he had represented to Oxford. In opposition, Oxford does not raise performance of the Procedures as an issue of fact. Accordingly, Josephson's motion for summary judgment to dismiss the fraud claim as it relates to performance of the procedure is granted.

2. The Procedures' Medical Necessity

Oxford alleges that Josephson misrepresented to it that all of the Procedures performed were medically necessary. In its motion, Oxford does not address this issue.

In his motion, Josephson claims that all of the Procedures in question were medically necessary. In support, he provides two affidavits by Dr. Rick G. Love ("Dr. Love"), a board certified otolaryngologist, who states that he reviewed the files of a total of 89 Josephson's patients who underwent the Procedures, and claims that each Procedure that he reviewed was medically necessary.

However, Dr. Love does not provide any information as to the identity of the patients whose claims he reviewed. Given that the list of patients in question has changed several times in the course of this action, and even these motions, on this record, it cannot be determined whether Dr. Love reviewed the claims of the latest 85 Members in question. The issue of medical necessity requires an individualized inquiry on a patient-by-patient basis, and cannot be determined for a group of patients. *See e.g. Batas v. Prudential Ins. Co. of Am.*, 37 A.D.3d 320, 322 (1st Dept. 2007). Accordingly, Josephson has not made a prima facie showing of entitlement to judgment that, with respect to the 85 Members, he did not misrepresent to Oxford that the Procedures were medically necessary, which defeats his motion in this respect. *See generally Pirrelli v. Long Is. R.R.*, 226 A.D.2d 166, 167 (1st Dept. 1996).

3. Outstanding Balance Payments

In its motion, Oxford addresses its allegation that Josephson misrepresented to it that he had collected deductible and co-insurance payments from his patients, when, in fact, he did not. Accordingly, pursuant to the insureds' policies, Oxford was allegedly either not obligated to make any payments to Josephson at all, or Oxford overpaid

Josephson to the extent that its reimbursements were based on his purported fees, which were higher than his actual fees. Another theory that Oxford seems to pursue is that Josephson's alleged waiver of his Oxford patients' balance payments enabled them to "overutilize" or undergo the Procedure more frequently and more times then they would have had they been making balance payments.

In its final submission on its motion, Oxford claims that, out of 85 Members in question, Josephson failed to collect any payments from 26 and collected only a fraction of outstanding balances from the other 59. In support of its argument, Oxford relies primarily on *Long Is. Pulmonary Assoc. v. Metro. Life Ins. Co.* (Sup. Ct., Nassau County, Jan. 14, 2003, Warshawsky, J., Index No. 023531/99) (NYLJ, Feb. 14, 2003, at 24, col 6) (*"LIPA"*) and *Kennedy v Connecticut Gen. Life Ins. Co.* (924 F.2d 698 [7th Cir 1991]) (*"Kennedy"*).

In *LIPA*, an insurer was responsible for 80% of a non-participating doctor's allowed fee, and an insured was responsible for the balance. Both the doctor's testimony and the insurer's survey of his patients established that the doctor waived the patients' deductible and co-insurance obligations on a consistent basis. The insurer sought summary judgment on its counterclaims against the doctor for fraud, intentional interference with contractual relations, and unjust enrichment. The *LIPA* court held that the doctor falsely represented to the insurer the amount of his real fee, which was the fee that he was willing to accept, not the fee that he charged, and that, as a result, the insurer was damaged by paying 20% more of what it should have paid. *See LIPA* Decision, at 3.

The *LIPA* court, however, could not determine whether the doctor misrepresented to the insurer with intent to defraud and denied the insurer's motion as to its counterclaim for fraud, but granted it as to the other two counterclaims. *See id.* at 5-6.

In *Kennedy*, an insured, whose group health policy obligated her to pay 20% of a doctor's fee, saw a chiropractor. The chiropractor and the insured executed a contract, pursuant to which the doctor "agreed to accept as full compensation whatever the insurer would pay" *Kennedy*, 924 F.2d at 699. The *Kennedy* Court noted that as a result of his waiver of co-payments, the doctor's actual fee was 20% less than what he had represented to the insurer. The insured's policy provided that the insurer was not obligated to pay anything to a medical provider if the insured was not legally required to pay her part to the provider. *Id.* at 701. The co-payment was meant to provide financial incentive to the insureds to "moderate their demands for medical service." *Id.* at 701. The *Kennedy* Court affirmed the district court's determination that because, pursuant to the contract with the doctor, the insured was not financially obligated to the provider, the insurer was not obligated to reimburse the provider either. *Id.* at 701-702.

Finally, Oxford relies on several opinions of the General Counsel of the New York Department of Insurance (the "GC"). The GC has stated that "a physician who, *as a general business practice*, waives otherwise applicable co-insurance, co-payments, or deductibles, where such waiver would affect the amount the insurer would pay might be guilty of insurance fraud pursuant to N.Y. Penal Law § 176.05 (2) and N.Y. Ins. Law § 403 (c)." Opinion No. 05-04-07, 2005 NY Insurance GC Opinions LEXIS 86, *2

(emphasis added); *see also* Opinion No. 04-02-25, 2004 NY Insurance GC Opinions LEXIS 46, *1-3; Opinion No. 03-04-09, 2003 NY Insurance GC Opinions LEXIS 26, *1-5). At the same time, "a [medical provider's] decision, in the exercise of business judgment, not to pursue the full legal remedies available to collect a debt would not constitute insurance fraud." 2003 NY Insurance GC Opinions LEXIS 26, *5.

Here, when the parties appeared for an oral argument held on September 23, 2008, the court (Lehner, J.) was concerned that the record on the motions did not reveal whether or not Josephson, as a business practice, waives his patients' financial obligations, including deductible and co-insurance payments. It appears that one of the reasons that the court ordered additional discovery was to address this issue.

In its latest submission, after additional discovery took place, Oxford, however, does not specify how many of its insureds underwent the Procedure with Josephson in the relevant time period, which appears to have changed multiple times in the course of this action. Oxford's statement that "the 85 Members at issue on [its] summary judgment motion" implies that there may be other insureds who have undergone the Procedure with Josephson within the relevant period of time. Oxford only claims that 26 insureds paid nothing to Josephson and the other 59 paid a fraction of their outstanding balances.

Oxford's showing, however, is insufficient to establish a pattern of waiver by Josephson of his patients' financial obligations on a regular basis, which is what Oxford needs to show to establish misrepresentation. *cf.* Opinion No. 05-04-07, 2005 NY Insurance GC Opinions LEXIS 86, *2 (insurance fraud may lie where there is "a general

business practice" to waive patients' balance payments); *LIPA* Decision, at 3 (the record showed that the doctor routinely waived his patients' balance payments); *Kennedy*, 924 F.2d at 701-702 (a contract between the doctor and the patient showed that the patient had no financial obligations to the doctor). Accordingly, Oxford's motion, with respect to its allegation that Josephson misrepresented to it that he collected Balance Payments from his patients, is denied.

On his motion, Josephson has shown that, as a general business practice, he holds his patients responsible for all of his charges, as well as for their deductible and co-insurance obligations. Josephson produces copies of his forms that his patients sign, pursuant to which they are obligated to make balance payments, as well as redacted copies of his patients' personal checks and credit cards as evidence of their payment for his services.

Josephson's billing clerk, Janice Cedeno, testified about how she records the patients' financial obligations, balance bills them, and pursues collection of outstanding balances. Josephson represents that he has collected more than $500,000 from his patients. Additionally, the overwhelming majority of Josephson's patients, whom Oxford surveyed, stated that he held them financially responsible for his services. Finally, in the consolidated action, *Josephson v Lastra*, Index No. 106655/04, Josephson is suing his former patient for outstanding balance payment. Accordingly, Josephson has established that he does not routinely waive his financial obligations, and Oxford has failed to come forth with necessary evidence that would create an issue of fact. Josephson's motion for

summary judgment dismissing Oxford's fraud claim as it relates to billing practices is therefore granted.

C. Unjust Enrichment

"To state a cause of action for unjust enrichment, a plaintiff must allege that it conferred a benefit upon the defendant, and that the defendant will obtain such benefit without adequately compensating plaintiff therefor." *Nakamura v Fujii*, 253 A.D.2d 387, 390 (1st Dept. 1998). Oxford claims that Josephson induced his patients to undergo excessive Procedures, and, as a result, received payments from Oxford and the patients to which he was not entitled. In its latest submission, Oxford seeks summary judgment on its unjust enrichment claim.

"The burden of proving that a claim falls within the exclusions of an insurance policy rests with the insurer." *Neuwirth v. Blue Cross & Blue Shield of Greater N.Y.*, 62 N.Y.2d 718, 719 (1984). As previously discussed, Oxford may deny reimbursements to Josephson, the assignee, on the same grounds that it would do so to its insureds, the assignors. *See e.g. Long Is. Radiology*, 36 A.D.3d at 765; *West Tremont Med. Diagnostic*, 13 Misc.3d at *3.

Oxford provides an excerpt from a typical Oxford policy that lists specific grounds for coverage exclusion. Lack of medical necessity is one of them, as well as "[a]ny . . . treatment for which the Member has no legal obligation to reimburse the provider." Oxford's policy also provides that "[a]ll Covered Services will be subject to Deductibles,

Coinsurance and UCR . . . " and that "[c]harges for Covered Services that exceed UCR are not Covered . . . ."

1. Number of the Procedures

Originally, with respect to the 54 patients, Oxford determined that any Procedure above four per patient was excessive and demanded that Josephson return it $213,045.

On its motion Oxford does not raise the issue of unjust enrichment on the basis of Josephson's performing more than four Procedures per patient. In his motion, Josephson argues that a number of times a patient needs the Procedure must be determined only on a case-by-case basis. In support, he offers a letter from the American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS), as well as the testimonies of Oxford's own witnesses, Drs. David Volpi and David Michael Wasser, all of which state that the Procedure's necessity is a case-by-case determination by a treating physician. Furthermore, Josephson contends, and Oxford does not dispute, that the publication by the American Medical Association, on which Oxford relied in limiting reimbursements to four Procedures per patient, does not constitute an authoritative recommendation, supported by research, on an appropriate number of the Procedures.

Oxford offers an affidavit of its consultant otolaryngologist, Dr. Michael P. Scherl, in support of its policy of accepting or denying reimbursement claims based merely on a specific number of Procedures. Dr. Scherl alleges that Oxford's policy is based on the recommendation of the AAO-HNS. However, he does not cite any particular publication by the AAO-HNS stating so, whereas Josephson, as already discussed, offers a letter

from the AAO-HNS that explicitly denies that it is its position, and provides that an appropriate number of Procedures is a case-by-case determination.[6] Additionally, Dr. Scherl's claim that Josephson administers the Procedure more frequently than any other Oxford provider, is not a valid defense that Oxford can use in denying reimbursements to Josephson. *See e.g. Long Is. Radiology*, 36 A.D.3d at 765; *West Tremont Med. Diagnostic*, 13 Misc.3d at *3. Accordingly, Josephson has shown, and Oxford has failed to contradict, that the number of Procedures that are medically necessary needs to be determined on a patient-by-patient basis. Therefore, if Oxford wishes to pursue its claim that Josephson was unjustly enriched because he was reimbursed for "excessive Procedures," it may not use a predetermined number of Procedures per patient in order to show that. Rather, Oxford must show that every Procedure in question was medically unnecessary. *See Long Is. Radiology*, 36 A.D.3d at 765; *West Tremont Med. Diagnostic*, 13 Misc.3d at *3.

2. Failure to Collect Balance Payments

In its motion, Oxford addresses its allegation that Josephson was unjustly enriched because he failed to collect balance payments from his patients. As a result, his bills to

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[6] In the 05/28/99 AAO-HNS letter, Dr. Michael D. Maves wrote to Oxford, "[t]here is no foundation in fact to your stated position that this code should be limited to five times, and [that] certainly is not the position of the AAO-HNS. In fact, we feel that limiting the number of these debridements can severely jeopardize the quality of care which the patients receive and affect the overall outcome of such sinus surgery in a negative way."

Oxford allegedly did not reflect his actual charges, whereas Oxford reimbursed him based on fees stated in the bills[7] (*see e.g. LIPA*, at 4).

As previously discussed, in its final submission, Oxford represents that the claims of 85 Members are at issue, and that 26 of them paid nothing to Josephson, whereas the other 59 paid him a fraction of their outstanding balances.

Oxford provides a list of the 26 patients in question. Oxford, however, does not point to any records that would show (1) that these patients, in fact, underwent CPT 31237 Procedure(s) with Josephson; (2) the amount of fees charged by Josephson for the Procedures; (3) the reimbursements paid by Oxford; and (4) the outstanding balance amounts.[8] Some of the 26 Members do not appear as having underwent a CPT 31237 Procedure on the Geanuracos Chart, which was the original list of the patients in question on Oxford's motion (*see* n 5, *supra*). Accordingly, Oxford has failed to make a prima facie showing of entitlement to summary judgment that Josephson was unjustly enriched with respect to the 26 Members. *See e.g. Pirrelli*, 226 A.D.2d at 167).

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[7] Oxford also claims that Josephson's patients, unburdened by the Balance Payments, utilized his services more frequently than they would have had they been obligated to pay. Oxford offers no tangible proof in support of this allegation.

[8] To the extent that records for Patrick B., who appears to be one of the 26 Members, are attached as part of exhibit 9 to the 12/07/09 McNamara Affidavit, Patrick B.'s records list eight CPT 31237 Procedures performed after January 1, 1997. Josephson apparently charged a total of $12,225 for eight Procedures, including one on 2/4/99 when some additional treatment was rendered. Oxford paid Josephson for only four Procedures, totaling $3,600, and the patient apparently did not pay anything. Oxford, however, does not explain to what extent, if at all, it overpaid Josephson in this case.

Oxford alleges that with respect to the other 59 Members (the 59 Members), Josephson billed Oxford a total of $3,291,361.22, and that Oxford reimbursed Josephson a total of $1,333,490.90. Of the remaining balance of $1,940,923.02, the 59 Members allegedly paid Josephson only a total of $157,125.13.

Josephson argues, and the pertinent records show, that Oxford's numbers are inflated, because the aforementioned charges pertain to both CPT 31237 Procedures and other treatments and services provided by Josephson that are not a subject of this action. Oxford has never amended its complaint to include Josephson's medical services other than CPT 31237 Procedures. Accordingly, with respect to the 59 Members, the record shows that Josephson did not charge $3,291,361.22 for the CPT 31237 Procedures, and that Oxford, correspondingly, did not pay him a total of $1,333,490.90.

The record also shows that two patients paid for the Procedures (*see* 12/07/09 McNamara Aff., exhibit 9, at Bates stamp Josephson 10-6-08 235, 264 [David paid $350 for a Procedure on 01/05/98 and Jonathan paid $69.90 for a Procedure on 01/17/00]). The records of the other insureds in question, however, do show that they did not pay for their CPT 31237 Procedures. Therefore, Oxford has demonstrated that 57 Members did not make any balance payments for their respective CPT 31237 Procedures.

In opposition, Josephson contends that purported outstanding balances are exaggerated because Oxford, in its turn, (1) has failed to reimburse him to the extent that

it is contractually required,[9] and (2) used UCR-setting methods that were found by the New York Attorney General's Office to result in artificially low reimbursement rates.

Josephson's billing clerk, Janice Cedeno, testified that when a patient undergoes a Procedure, the office policy is to bill the insurance company first and then to bill the patient for the balance. Josephson claims that his patients are reluctant to pay their outstanding balances when they know that Oxford has not reimbursed Josephson to the extent that it is obligated. Josephson represents that he, nonetheless, holds his clients financially responsible for any outstanding balances and attempts to collect them. Janice Cedeno described Josephson's specific efforts to collect Balance Payments from some of the 59 Members in question. Accordingly, issues of fact exist as to (1) the correct amount that Josephson charged, and was reimbursed by Oxford, for the CPT 31237 Procedures; (2) whether Oxford reimbursed Josephson to the extent required by the Oxford policies of the 59 Members in question and at appropriate UCRs; and (3) whether Josephson has waived the financial obligations of the 59 Members, minus two payments made by the aforementioned two patients.

The parties submit conflicting evidence as to whether precertification is required before a Procedure is administered, and, therefore, an issue of fact exists as to whether Oxford requires precertification for the Procedures, which may affect the amount of

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[9] Josephson commenced a lawsuit against Oxford in Nassau Supreme Court, captioned *Jordan S. Josephson, M.D. v Oxford Health Insurance, Inc.*, index No. 0443/07 (the "Nassau Action"), to collect payments for the medically necessary Procedures performed.

reimbursement to which Josephson is entitled. Accordingly, Oxford's motion on its unjust enrichment cause of action is denied.

Josephson, in turn, has failed to show that he held all of the 59 Members in question financially responsible for his charges or that he has made efforts to collect outstanding balances from each one of them. Accordingly, his motion in this regard is denied as well.

In accordance with the foregoing, it is hereby

ORDERED that the motion of plaintiff Oxford Health Insurance, Inc. for summary judgment on its complaint is denied; and it is further

ORDERED that the motion of defendant Jordan S. Josephson, M.D. for summary judgment dismissing the complaint insofar as asserted against him is granted only to the extent that the cause of action for breach of contract is dismissed, that part of the cause of action for fraud that is based on the allegations that Jordan S. Josephson, M.D. misrepresented to Oxford Health Insurance, Inc. that he had performed all of the

Procedures for which he billed and that he collected his Oxford Health Insurance, Inc. patients' deductible and co-insurance payments is dismissed and the motion is otherwise denied; and it is further

ORDERED that the remainder of the action is severed and shall continue.

This constitutes the decision and order of the court.

Dated: New York, New York
July 23, 2010

ENTER:

Saliann Scarpulla, J.S.C.