

Not Reported in F.Supp.2d, 2005 WL 2007894 (S.D.N.Y.)  
(Cite as: **2005 WL 2007894 (S.D.N.Y.)**)

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United States District Court,  
S.D. New York.  
Allen CHAMBERLIN, M.D., Carnegie Hill Ortho-  
pedic Services, P.C. and Devonshire Surgical Facil-  
ity, LLP, Plaintiffs,  
v.  
THE HARTFORD FINANCIAL SERVICES INC.,  
et al., Defendants.

No. 05 Civ. 2650(AKH).  
Aug. 19, 2005.

*MEMORANDUM AND ORDER DISMISSING  
COMPLAINT*

HELLERSTEIN, J.

\*1 Plaintiff Allen Chamberlin, his medical prac-  
tice, and a surgical center have filed a complaint to  
recover treble monetary damages and reasonable at-  
torneys fees for alleged violations of RICO, [18  
U.S.C. § 1962\(b\), \(c\), and \(d\)](#) by defendant insurance  
companies. The defendants have moved to dismiss  
the complaint pursuant to [Fed.R.Civ.P. 12\(b\)\(6\)](#). Be-  
cause Plaintiffs have failed to state a cause of action  
for which relief can be granted, I grant the motion  
and dismiss the Complaint against each defendant.

I. Facts

Plaintiff Allen Chamberlin, M.D. is a Board Cer-  
tified Orthopedic Surgeon formerly licensed to prac-  
tice medicine in New York State.<sup>FNI</sup> Dr. Chamberlin  
is the sole shareholder of plaintiff Carnegie Hill Or-  
thopedic Services, P.C. (“Carnegie”), through which  
he conducts his medical practice. Devonshire Surgi-  
cal Facility operates a surgical facility at which Dr.  
Chamberlin performed orthopedic surgery and other  
medical services.

FNI. On July 22, 2005, the New York State  
Department of Health, State Board for Pro-  
fessional Conduct revoked Dr. Chamberlin's  
license to practice medicine in New York  
State and fined him \$30,000, finding that he  
“deliberately concealed information in his  
records and reports so that he could bill the

insurance company for procedures that he  
did not perform.” *In the Matter of Allen C.  
Chamberlin, M.D.*, BPMC No. 05-160 at 21.

The Complaint alleges that at various times be-  
tween 1996 and 2004, Chamberlin provided orthope-  
dic care, surgery, post-operative care and other medi-  
cal services to 460 patients involved in automobile  
accidents and whose injuries and the treatment  
thereof were subject to the provisions of No-Fault  
insurance policies issued to them by the respective  
defendants.

The defendants are insurance companies that un-  
derwrote and issued policies of automobile insurance  
in New York State in compliance with the New York  
Comprehensive Motor Vehicle Insurance Repara-  
tions Act, [N.Y. Ins. Law § 5101](#), et seq. and the regulations  
promulgated thereunder.

The instant Complaint appears to stem from de-  
nials by the defendant insurance companies to reim-  
burse Chamberlin for claims submitting pursuant to  
his patients' no-fault insurance policies. Plaintiffs  
initially brought claims in state court alleging breach  
of implied contract and breach of the common law  
duty of good faith and fair dealing. In late January  
2005, Plaintiffs withdrew the State Court Complaint  
and filed this federal action.

The Complaint names as predicate acts for the  
RICO claims “indictable violations” of the federal  
mail and wire fraud statutes. *See* [18 U.S.C. §§ 1341,  
1951\(b\)\(2\), 1951\(a\)\(3\)](#). Plaintiffs allege that Defen-  
dants committed five general categories or types of  
fraud. First, Plaintiffs allege a denial of payment re-  
quests based upon cost criteria rather than coverage  
and medical necessity. Second, Plaintiffs allege that  
the insurers “downcoded” the codes submitted by  
plaintiffs to codes that provided reimbursement at a  
lower rate than plaintiffs requested, and that the in-  
surers “bundled” codes together so that multiple  
treatments would be reimbursed as a single treatment.  
Third, Plaintiffs allege that defendants engaged in a  
practice of “calculated understaffing” which resulted  
in claims by the insurance companies that certain  
claim forms were not received or lost. The fourth  
allegation is that the Explanation of Benefits forms

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that Defendants provided with their payment determinations “misrepresented and/or concealed the actual manner in which Plaintiffs’ payment requests were processed.” (Complaint ¶ 63). Fifth, the Plaintiffs allege that the Defendants refused preauthorization of orthopedic surgery.

\*2 Plaintiffs allege that the defendants constitute a RICO “enterprise” consisting of

“(1) Defendants; (2) other health insurance companies not named as Defendants herein; (3) “specialty healthcare networks” who have organized themselves for the purpose of assisting, perfecting, and furthering Defendants’ plans to minimize Defendants’ payments to Plaintiffs and other similarly situated healthcare providers; (4) third party entities which use actuarial and other information to promulgate purported patient care guidelines and assist Defendants in the development of their financial risk assessments for coverage to subscribers; (5) third party entities which develop claims processing systems or components used by Defendants and others to evaluate and process claims, reduce payments of claims, or deny claims of Plaintiffs and other healthcare professionals; and (6) third party entities Defendants hire to review and wrongfully deny claims.” (Compl.¶ 74).

The Complaint contains six counts: (1) a RICO violation under [18 U.S.C. § 1962\(a\)](#) (prohibiting investment of racketeering activity proceeds in the establishment or operation of a RICO enterprise); (2) a RICO claim under [18 U.S.C. § 1962\(c\)](#) (prohibiting RICO “persons” from “conducting or participating in” the conduct of a RICO enterprise’s affairs through a “pattern of racketeering activity.”); (3) participation in a RICO conspiracy in violation of [18 U.S.C. § 1962\(d\)](#); (4) aiding and abetting of RICO violations under [18 U.S.C. § 2](#); (5) a request for declaratory and injunctive relief to prevent Defendants from future RICO violations; (6) a common law claim for unjust enrichment.

## II. Discussion

### A. Standard for Motion to Dismiss

In deciding a whether to grant a motion to dismiss, the court must “take as true all allegations in the complaint, and draw all reasonable inferences therefrom in the plaintiff’s favor.” [Koppel v. 4987](#)

[Corp.](#), 167 F.3d 125, 130 (2d Cir.1999). Additionally, all reasonable inferences are drawn in favor of the plaintiff. [McCall v. Pataki](#), 232 F.3d 321, 322 (2d Cir.2000). A plaintiff charging RICO violations under [18 U.S.C. § 1962\(c\)](#) must allege: “(1) that the defendant (2) through the commission of two or more acts (3) constituting a ‘pattern’ (4) of ‘racketeering activity’ (5) directly or indirectly ... participates in (6) an ‘enterprise’ (7) the activities of which affect interstate commerce or foreign commerce.” [West Hartford v. Operation Rescue](#), 915 F.2d 92, 100 (2d Cir.1990). Plaintiffs have not alleged any facts sufficient to constitute “predicate acts” for racketeering under RICO. Therefore, the Complaint against Defendants is dismissed.

### B. Plaintiffs Fail to State a Claim for Mail and Wire Fraud

Plaintiffs allege that Defendants engaged in a pattern of racketeering activity through predicate acts of mail and wire fraud. However, none of the facts alleged, nor inferences to be drawn from those facts, suggest that Defendants have engaged in fraudulent activity. Read in the light most favorable to Plaintiffs, the facts alleged demonstrate that the Defendants have not fulfilled their obligations under a contract-express or implied-to Plaintiffs. However, claims based on failure to perform under a contract do not state a claim for fraud. [Great Earth Int’l Franchising Corp. v. Milks Development](#), 311 F.Supp.2d 419, 428 (S.D.N.Y.2004).

\*3 Under New York law, “where a party is merely seeking to enforce its bargain, a tort claim will not lie.” [New York University v. Continental Ins. Co.](#), 87 N.Y.2d 308 (1995). Of the five types of fraud alleged in the complaint, four of these describe actions that are ordinary breach of contract actions. As the Second Circuit has held, “a plaintiff is not allowed to ‘dress-up’ a breach-of-contract claim as a fraud claim.” [Cohen v. Koenig](#), 25 F.3d 1168, 1173 (2d Cir.1994), citing [Triangle Underwriters, Inc. v. Honeywell, Inc.](#), 604 F.2d 737 (2d Cir.1979). These claims are of a solidly common-law nature. “RICO was not enacted for the purpose of providing a Federal forum for nearly every conceivable contract action under State law.” [Goldfine v. Sichenzia](#), 118 F.Supp.2d 392, 399-400 (S.D.N.Y.2000).

The only allegation that even approaches a claim of fraud is the claim that Defendants somehow mis-

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represented or concealed how insurance claims were processed. However, a misrepresentation does not rise to the level of a fraud claim unless it is a misrepresentation concerning a matter which is “collateral or extraneous” to the contract. [Great Earth, 311 F.Supp.2d at 427](#). Because the alleged misrepresentations were contained within the policies, the alleged misrepresentations cannot possibly be considered collateral or extraneous to the policies. *See id.*

Plaintiffs have an adequate forum to pursue these contract claims in State Court. New York law provides complete remedies for insureds and their assignees, such as Plaintiffs, who believe that their claims have been improperly denied. *See N.Y. Ins. Law §§ 5102 and 5108; 11 N.Y. C.R.R. §§ 65-3.9 and 65-2.10*. Under the No-Fault Law, a health care provider challenging the denial or reduction of an claim may file either a Personal Injury Protection lawsuit or may commence arbitration against an insurer. [N.Y. Ins. Law § 5106; 11 N.Y. C.R.R. §§ 65-3.9 and 65-3.10](#).

#### *C. Plaintiffs Fail to Plead Fraud Allegations With Particularity*

[Rule 9 of the Federal Rules of Civil Procedure](#) requires that “[i]n all averments constituting fraud and mistake, the circumstances constituting fraud and mistake shall be stated with particularity.” [Fed.R.Civ.P. 9\(b\)](#). Therefore, in order to sustain a RICO cause of action with predicate acts of mail and wire fraud, Plaintiffs must plead the fraud aspects of their allegations with particularity.

The Second Circuit has held that “[t]o satisfy the particularity requirement of [Rule 9\(b\)](#), a complaint must adequately specify the statements it claims were false or misleading, give particulars as to the respect in which plaintiff contends the statements were fraudulent, state when and where the statements were made, and identify those responsible for the statements.” [Cosmas v. Hassett, 886 F.2d 8, 11 \(2d Cir.1989\)](#).

Plaintiffs have not met this burden. The Complaint states only general allegations against the many insurer defendants. It does not provide any examples of specific fraudulent behavior by any of the defendants. Rather, the plaintiffs have attached a list of patient claims that they allege are unpaid by defendants. At best, these lists establish particular in-

stances of breach of contract by specific defendants. This is not the sort of “stringent adherence to the particularity requirement” that courts require in RICO cases “where the predicate fraud allegations provide the only link to federal jurisdiction.” [Clifford v. Hughson, 992 F.Supp. 661, 666 \(S.D.N.Y.1998\)](#).

#### III. Conclusion

\*4 I hold that Plaintiffs have not state a claim for which relief may be granted. [Fed.R.Civ.P. 12\(b\)\(6\)](#). The case is dismissed against all defendants and the Clerk shall mark the case as closed.

SO ORDERED.

S.D.N.Y.,2005.

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