NOT TO BE PUBLISHED WITHOUT THE APPROVAL OF THE COMMITTEE ON OPINIONS

THOMAS R. PETERSON, M.D., P.C.,

Plaintiff,

-vs-

AETNA LIFE INSURANCE, COMPANY,

Defendants

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: BERGEN COUNTY
DOCKET NO. BER-L-1759-15

FILED
JUN 14 2016
ESTELA M. DE LA CRUZ
J.S.C.

DECISION ON APRIL 29, 2016 MOTION FOR SUMMARY JUDGMENT And May 6, 2016 CROSS MOTION FOR SUMMARY JUDGMENT

Argued: **June 10, 2016**

Decided: **June 14, 2016**

Honorable Estela M. De La Cruz, J.S.C.

Edward S. Zizmor, Esq., appearing for the Plaintiff, Thomas R. Peterson, M.D., P.C.

Matthew A. Baker, Esq., appearing for the Defendants, AETNA (Connell Foley)

Procedural Background

This matter comes before the Court by way of, Defendant, AETNA Life Insurance's ("AETNA") motion for Summary Judgment filed April 29, 2016 and by way of Plaintiff Thomas R. Peterson, M.D., P.C.'s ("Peterson") cross-motion for Summary Judgment filed on May 6, 2016. Oral argument was heard on June 10, 2016. This is a decision in an earnest effort to satisfy R. 1:7-4(a). These motions are ripe for such review inasmuch as discovery ended on April 15, 2016 and a trial is scheduled on June 27, 2016. No issue of prematurity has been raised in these papers.

Factual Background

The lawsuit arises from a dispute involving surgical services Plaintiff rendered to a patient on December 27, 2013. Plaintiff doctor did not have a contract with AETNA and

thus was out-of-network in providing the services. The medical treatment rendered was non-emergent, and was elective. The patient received health insurance through an ERISA plan which was administered by AETNA. As Plaintiff doctor was out-of-network, he requested for AETNA to pre-certify the claims at issue on December 26, 2013. Plaintiff submitted a claim for the services rendered in the amount of $179,882.85. AETNA pre-certified the procedure intended by Plaintiff doctor and AETNA processed the claim on February 21, 2014. As a result of AETNA's pre-certifications and approval, AETNA paid Plaintiff $157,309.25 for the procedure performed on the insured patient. After processing and paying the claim, AETNA claims to have learned that the patient was also eligible for Medicare and, as a result, AETNA believed it should have been paid secondary to Medicare. On March 22, 2014, AETNA sought to recover payment made in this matter by offsetting the amount paid from future amounts owed to Plaintiff doctor. AETNA has withheld some payments and to date $70,170.92 remains sought by AETNA.

Plaintiff filed the instant action on February 18, 2015 seeking to recover the amounts both withheld and taken back by AETNA. Defendant AETNA seeks summary judgment alleging that Plaintiff has no viable causes of action to pursue at this time it. Plaintiff cross-moved for his own summary judgment relief, arguing that his claims against AETNA are ripe for summary judgment under a breach of contract and/or promissory estoppel theories.

ARGUMENTS

In its summary judgment motion, AETNA first argues that Plaintiff's state law claims for breach of contract and misrepresentation are preempted by the Employee Retirement

Income Security Act ("ERISA"). Specifically, AETNA states that Section 502(a) of ERISA completely preempts Plaintiff's state law claims against AETNA because it seeks to supplement the exclusive remedies that are available under 29 U.S.C. § 1132 (a). Pryzbowski v. U.S. Healthcare, 245 F.3d 266, 271-72 (2d Cir. 2001). AETNA also cites to Section 514(a) of ERISA in further support that Plaintiff's state laws are preempted because these claims relate to an employee benefit plan pursuant to 29 U.S.C. § 1144 (a). AETNA argues that courts have repeatedly held that Section 514 (a) of ERISA preempts state law claims that an insurer misrepresented the amount or availability of benefits under any employee benefit plan. Kelso v. General American Life Ins. Co., 967 F.2d 388, 391 (10th Cir. 1992).

In addition to arguing that Plaintiff is preempted by ERISA, AETNA also claims that Plaintiff lacks sufficient standing to bring a cause of action against AETNA for medical services the doctor rendered to his patient. AETNA argues that the only instrument by which Plaintiff can bring forth the claims sought in the Complaint is by way of an assignment of benefits from the patient to whom medical care was provided to. AETNA's position is that without such an assignment, Plaintiff does not have standing to sue to enforce the terms under the contract between AETNA and their insured. On this point, AETNA relies on Parkway Ins. Co., v. N.J. Neck and Back, 330 N.J. Super. 172, 187 (Law Div. 1998). As there is no assignment between the Plaintiff and AETNA's insured (Dr. Peterson's patient), and because there is no other contract between AETNA and Plaintiff, AETNA argues that the Complaint should be dismissed for lack of standing.

Finally, AETNA argues that its decision to seek back erroneous payments it made to Plaintiff must be upheld because a court is required to give full effect to the terms of a

contract for insurance when its terms are clear. James v. Federal Ins. Co., 5 N.J. 21, 24 (1950). Courts may only overturn a plan administrator's denial of coverage if it is without reason, unsupported by substantial evidence, or erroneous as a matter of law. Gambino v. Anrouk, 232 Fed. Appx. 140, 145 (3d Cir. 2007). AETNA claims that the subject plan provides that when a participant becomes eligible for Medicare, Medicare shall be his or her primary health care provider. AETNA points out that the patient here was receiving benefits through the Consolidated Omnibus Budget Reconciliation Act ("COBRA") and was eligible for Medicare Part B. Therefore, AETNA states it was mandated and within its rights to have the claim re-processed as secondary to Medicare. Thus, AETNA's decision to seek repayment was not arbitrary and capricious and must be upheld.

In opposing AETNA's motion and in support of his own summary judgment relief, Plaintiff argues that this case is not preempted by ERISA. Specifically, Plaintiff cites to Pascack Valley Hospital v. Local 464A, UFCW Welfare Ca (NJ), 388 F.3d 393 (3d Cir. 2004). In Pascack, the Appellate Division held that Plaintiff's claim for unpaid medical services were pled as a state common law claim for breach of contract, and did not refer to ERISA or the rights and immunities created under ERISA. Plaintiff further notes, the Pascack Court held that removal to federal court would have only applied if the hospital could have brought its breach of contract claim under 502(a) of ERISA and if no other legal duty attached to the hospital's claim. Peterson argues that just like the Pascack Plaintiff, it is similarly suing for a breach of contract claim, not ERISA claims. Peterson argues its Complaint does not deal with assignment or benefits of the plan, but instead involves state law claims for breach of contract that arose when Defendant pre-certified the claims sought

by Plaintiff. Peterson's position is that once AETNA pre-certified these claims they entered into a contract wherein Plaintiff provided medical services for AETNA's insured, and AETNA agreed to reimburse Plaintiff, which it did, but now seeks to recover.

In supports of the cross-motion for summary judgment, Peterson argues that the doctrine of promissory estoppel compels AETNA to make payments according to their pre-certification. The elements of promissory estoppel are: (1) a clear and definite promise by the promisor; (2) the promise must be made with the expectation that the promisor will rely thereon; (3) the promise must in fact reasonably rely on the promise; and (4) detriment of a definite and substantial nature must be incurred in reliance on the promise. Aircraft Inventory Corp. v. Falson Jet Corp., 18 F. Supp. 2d 409, 416 (1998). Peterson believes that there was a clear and definite promise made by Defendant to pay Plaintiff as evidence by the pre-certification and the fact that AETNA actually paid Plaintiff the amounts towards the claim, all consistent with the pre-certification. It was not until months later that AETNA reneged, advised of an alleged mistake, and began to take back money. Finally, Plaintiff disputes that his patient was ever eligible for Medicare based on the fact that when Plaintiff submitted the claims through Medicare, they were rejected. There is no other source of coverage that is primary, as AETNA claims and the Plaintiff should therefore be made whole.

AETNA opposes Plaintiff's cross-motion by arguing that the promissory estoppel theory now presented by Peterson was not pled in its Complaint and, further, that it has no factual support. AETNA cites to the fact that the pre-certification contains language that provides "please note that any benefit information furnished is not a guarantee of payment

nor a determination of medical necessity and final claim determination will be made upon receipt and review of the claim." AETNA argues that this language placed Plaintiff on notice that the pre-certification was not to be considered a promise to pay, and that all payments would be subject to a final review.

DISCUSSION

It is well settled that on a motion for Summary Judgment, the court must "consider whether the competent evidential materials presented, when viewed in the light most favorable to the non-moving party, are sufficient to permit a rational factfinder to resolve the alleged disputed issue in favor of the non-moving party." Brill v. Guardian Life Ins. Co. of Am., 142 N.J. 520, 540 (1995) and R. 4:46-2(c). This Court is not to resolve contested factual issues, but instead must determine whether there are any genuine factual disputes. Agurto v. Guhr, 381 N.J. Super. 519, 525 (App. Div. 2005). If there are any material facts disputed, the motion for Summary Judgment should be denied. Parks v. Rogers, 176 N.J. 491, 502 (2003); Brill, supra, 142 N.J. at 540. To grant the motion, the court must find that the evidence "'is so one-sided that one party must prevail as a matter of law.'" Brill, supra, 142 N.J. at 540 (quoting Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 252, 106 S. Ct. 2505, 2512, 91 L. Ed. 2d 202, 214 (1986)).

Defendant AETNA's Motion for Summary Judgment

The facts in this litigation are not in dispute and before the Court are issues of law. This Court finds that ERISA does not preempt the state law claims for breach of contract and misrepresentation pled in Plaintiff's Complaint. Addressing first, AETNA's argument for Summary Judgment on the basis of Section 502(a) of ERISA, this portion of ERISA is

jurisdictional in its scope creating a means of removal to federal court if appropriate. Pascack Valley Hosp., 388 F.3d at 398. As was the case in Pascack, Plaintiff's Complaint does not present a federal question, rather it only pleads state law contractual claims. Id. Here, as in Pascack, the Plaintiff does not refer to ERISA or the rights and immunities created under ERISA. Id. The mere possibility or likelihood that 502(a) may preempt Plaintiff's state law claims is not sufficient to grant Summary Judgment in favor of AETNA.

Concerning AETNA's arguments for Summary Judgment under Section 514(a) of ERISA, the Court finds that Plaintiff's claims do not "relate to" ERISA to such an extent that would warrant granting summary judgment. Under Section 514(a), ERISA "preempts state law claims that 'relate to' an ERISA plan. Specifically, the statute pertaining to express preemption provides, in pertinent part, that ERISA 'shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . .' 29 U.S.C. 1144(a)." St. Peter's Univ. Hosp. v. N.J. Bldg. Laborers Statewide Welfare Fund, 431 N.J. Super. 446, 455 (App. Div. 2013). The Appellate Division in St. Peter's conducted a thorough analysis of the applicability of Section 514(a). The St. Peter's Court noted that ERISA preempts state laws even when they are not directly affected by ERISA covered plans, however, while the ERISA preemptions provisions are expansive, they should not be interpreted to render those provisions in a limitless fashion. Id. at 455 (quoting Bd. of Trs. of Operating Eng'Rs Local 825 Fund Serv. Facilities v. L.B.S. Constr. Co., 148 N.J. 561, 566 (1997).

Further, a state law claim relates to an employee benefit plan if "the existence of an ERISA plan [is] a critical factor in establishing liability" and "the trial court's inquiry would be directed to the plan[.]" Id. (quoting 1975 Salaried Ret. Plan for Eligible Emps. of Crucible, Inc. v. Nobers, 968 F.2d 401, 406 (3d Cir.), cert. denied, 506 U.S. 1086 (1993). The Court in St. Peter's, in ultimately holding that the Plaintiff's claims were preempted, did so because "the claims 'would not exist but for the presence of an ERISA plan that provided coverage to the patient' and the Fund is essential to the suit. Id. at 460. Further in finding preemption was appropriate the St. Peter's court also noted that, "in order to adjudicate the Hospital's claims, the court would be required to examine and consult the terms of the ERISA plan to determine whether the Fund was liable under either state law cause of action." Id. This is not the case presented to this Court, where Plaintiff is alleging breach of contract claims based on promissory estoppel and in reliance of AETNA's pre-certification and subsequent payments in accordance with same. In analyzing and determining the merits of Plaintiff's claims, this Court would not necessarily be required to look to the ERISA plan, rather this Court is guided by the pre-certification and promises made to Plaintiff in accordance with the terms contained therein. Accordingly, this court denies grant summary judgment in favor of AETNA on the basis of preemption grounds.

With regards to AETNA's claim that Peterson lacks standing to bring these contractual claims, while neither party disputes that Plaintiff lacks an assignment on behalf of the patient to whom medical services were rendered to, there is evidence in the record that establishes an agreement between AETNA and Peterson, which was reached

before Peterson proceeded to performed the elective surgical procedure. While AETNA argues that Plaintiff failed to plead promissory estoppel in its Complaint, I note that in the Complaint, at paragraph six of Count One, Plaintiff states "Peterson relied on AETNA's representation of insurance coverage and performed surgery on AH December 27, 2013. Specifically he would not have performed the surgery if AETNA had not represented that it would pay Plaintiff's usual reasonable and customary fee for its medical services." Accordingly, although there is no magic language in the Complaint specifically wording "promissory estoppel", the Complaint incorporates this claim in an unstrained manner. The undisputed evidence before the Court shows that there was an agreement between the parties by way of AETNA's pre-certification that permitted the doctor to proceed with the elective procedure. This gives Plaintiff the standing to bring forth the claims sought in the Complaint.

Finally, AETNA's argument that its decision to deny coverage should be given its full effect because it was not arbitrary or capricious is not persuasive. AETNA couches this argument as if the bills in question were denied outright as originally submitted. The facts show that Peterson submitted a pre-certification of the bills to AETNA. These bills were then carefully scrutinized and reviewed by AETNA, which necessarily includes a review of the patient's age, applicable policy and plan coverage, and all other applicable policies that were needed to render a decision. AETNA, after conducting its review on its own terms, then pre-certified these bills. In essence, AETNA confirmed to Peterson that payment would be provided, but only for those services that were pre-certified. Only the services that were permitted by AETNA were performed and billed by Peterson and

pursuant to the parties' pre-certification arrangement and agreement, AETNA rendered payments totaling $157,309.25. It was only after these payments were made that AETNA then unilaterally decided that these payments were not appropriate and proceeded to withhold future payments on other claims submitted for medical services rendered to other Peterson's other patients. Simply put, AETNA may have mistakenly pre-certified these claims, but to argue that summary judgment is appropriate because AETNA was not arbitrary or capricious in seeking to correct this mistake ignores the fact that Peterson relied on AETNA's pre-certification in performing the medical services that it sought in its claims. Accordingly, based on the foregoing AETNA's motion for summary judgment is denied in its entirety.

Plaintiff Peterson's Cross-Motion for Summary Judgment

As noted above, a review of Plaintiff's Complaint does reveal to the Court that promissory estoppel was pled in paragraph 6. On a motion such as this, the motion judge is directed to search the Complaint in depth and with liberality to determine if a cause of action can be gleaned from even an obscure statement. Printing Mart v. Sharp Electronics, 116 N.J. 739, 746 (1989). Defendant's argument that promissory estoppel was not adequately pled is not persuasive after reviewing the Plaintiff's Complaint.

Promissory estoppel is made up of four elements: (1) a clear and definite promise; (2) made with the expectation that the promisee will rely on it; (3) reasonable reliance; and (4) definite and substantial detriment. Lobiondo v. O'Callaghan, 357 N.J. Super. 488, 499 (App.Div.), certif. denied, 177 N.J. 224 (2003). The record before this Court is clear and all four elements have been established in this record. The December 26, 2013 pre-

certification is a clear and definite promise that was made with the expectation that the promise would rely on it. The first sentence of the pre-certification document itself states "we have made a decision about coverage" placing Peterson on notice, in no uncertain terms, that AETNA has reviewed the claim submitted along with the subject policy and has determined whether or not the claims are covered. Further, attached as Exhibit 5 of Defense Counsel's certification is the full 6 page pre-certification document. At no point in those 6 pages of the pre-certification does the language cited by AETNA's opposition appear.

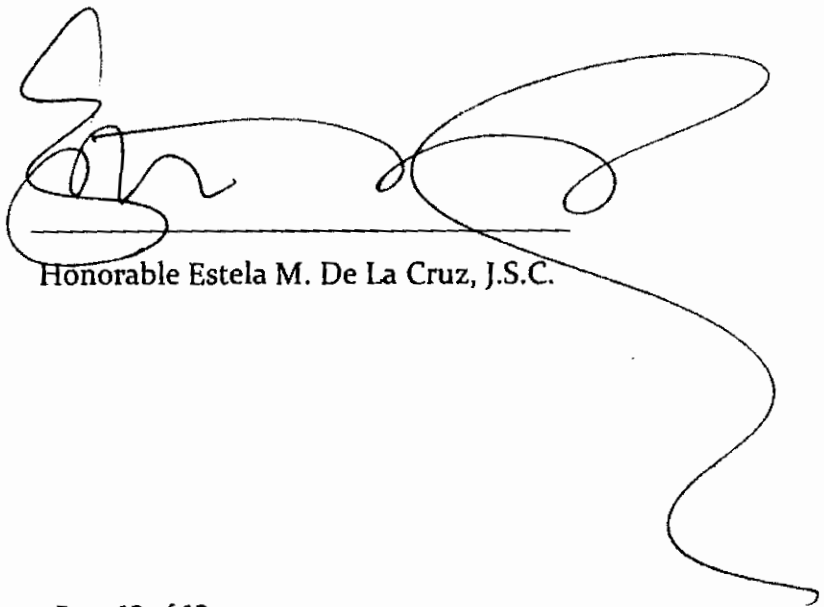
AETNA Claims the pre-certification does state, "please note that any benefit information furnished is not a guarantee of payment nor a determination of medical necessity and final claim determination will be made upon receipt and review of the claim. The language AETNA relies on does appear in Plaintiff's Exhibit B, as part of a 4 page fax that includes a header that states "Coverage & Benefits Basic Eligibility Information." Based on this Court's review of the pre-certification, there is nothing in that document that would indicate to Peterson it was anything else other than a clear and definite promise to pay, but only for the procedures described therein. Further, AETNA cannot say that it did not know that Peterson would rely on this promise as the very purpose of pre-certification is to confirm that Peterson would receive reimbursement for the medical services before they are performed.

The remaining elements of promissory estoppel are also present, as Peterson reasonably relied on AETNA's promise because Plaintiff eventually performed the medical services subject to the pre-certification. Finally, Plaintiff relied has also established a

definite and substantial detriment in reliance of AETNA's promise. Peterson performed the medical services on a non-emergent, but recommended surgery, for a definite sum totaling $179,882.85. Eventually AETNA made payments totaling $157,309.25, only to later seek to take back this payment by way of withholding payments on other claims that Peterson submitted to AETNA. There is no doubt that there is a definite and substantial detriment to Peterson were AETNA allowed to continue to withhold payments as Plaintiff would have performed the medical services without any compensation in exchange for that performance. Accordingly, based on the above, Plaintiff's cross-motion for Summary Judgment is granted.

CONCLUSION

For all of the foregoing reasons, Defendants' motion to dismiss for summary judgment is hereby DENIED and Plaintiff's cross-motion for summary judgment is hereby GRANTED. An Order has been signed by the Court on this day reflecting same.



Honorable Estela M. De La Cruz, J.S.C.

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ESTELA M. DE LA CRUZ
J.S.C.

THOMAS R. PETERSON MD PC

Plaintiff,

vs.

AETNA INSURANCE CO.

Defendant,

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: BERGEN COUNTY

DOCKET NO. BER-L-1759-15

CIVIL ACTION
ORDER
(5/6/16 Cross-motion)

THIS MATTER having been on for hearing ~~May~~ June 10, 2016, on Plaintiff's motion for summary judgment, EDWARD S. ZIZMOR ESQ., attorney for Plaintiff, upon notice to MATTHEW BAKER ESQ., of Connel Foley LLP., Attorneys for the Defendant, and the court having considered the matter the pleadings and other papers filed in this matter, having heard the argument of counsel on June 10, 2016 and good cause appearing and for reasons given in 12-page decision entered on this day of June

IT IS ON 14 day of ~~MAY~~ 2016

ORDERED that the Plaintiff THOMAS R. PETERSON MD PC is granted judgment against AETNA INSURANCE CO., in the sum of $179,882.85.

Estela M. De La Cruz

J.S.C. ESTELA M. DE LA CRUZ, J.S.C.

OPPOSED

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THOMAS R. PETERSON, M.D., P.C., Plaintiff, v. AETNA INSURANCE CO., Defendants.	SUPERIOR COURT OF NEW JERSEY LAW DIVISION/BERGEN COUNTY DOCKET NO.: BER-L-1759-15 Civil Action

ORDER
(4/29/16 MOTION)

THIS MATTER having come before the Court Matthew A. Baker, Esquire, attorney for Defendant Aetna Life Insurance Company ("Aetna"), for an Order granting Aetna's Motion for Summary Judgment, and the Court having considered the papers in support of said motion and in opposition thereto, and for good cause shown and for reasons set forth in 12 page decision of even date

IT IS on this 14 day of June 2016, ~~**ORDERED** that Plaintiffs Complaint be and hereby is **DISMISSED** with prejudice;~~

DENIED

IT IS FURTHER ORDERED that Defendant is hereby ~~**GRANTED**~~ summary judgment;

A copy of this Order shall be served upon all counsel/parties within seven (7) days of the date hereof.

ESTELA M. DE LA CRUZ, J.S.C.