2021 WL 1511282 (N.J.Super.L.) (Trial Order)
Superior Court of New Jersey, Law Division.
Hudson County

NEW JERSEY BRAIN AND SPINE, PC. d/b/a North Jersey Brain & Spine Center, Plaintiff,
v.
INDEPENDENT CARE GROUP PLUS TRUST, a/ka American Plan Administrators, a/k/a/ Mayer Rispler & Co.; Promise Care NJ a/k/a Healthcare Staffing & Consultants; and ABC Corps. 1-100, Defendants.

No. HUD-L-2416-20.
April 12, 2021.

*1 Civil Action
DED: 6/17/21
Trial Date: None
Arbitration Date: None

Opinion

Stuart Weinberger, Esq. – Goldberg and Weinberger LLP o/b/o Defendants Independent Care Group Plus Trust.

David M. Estes, Esq. – Mazie Slater Katz & Freeman o/b/o New Jersey Brain and Spine, P.C. d/b/a North Jersey Brain & Spine Center.

Christine M. Vanek, JSC.

DATE OF HEARING: MARCH 5, 2021

DATE OF DECISION: APRIL 12, 2021

CHRISTINE M. VANEK, J.S.C.

This matter comes before the Court by way of defendants Independent Care Group Plus Trust, a/k/a American Plan Administrators, a/k/a Mayer Rispler & Co.; Promise Care NJ a/k/a Healthcare Staffing & Consultants' motion to dismiss plaintiff's complaint pursuant to 4:6-2(e). Plaintiff opposed the motion.

A court considering an R 4:6-2(e) motion must examine "'the legal sufficiency of the facts alleged on the face of the complaint,' limiting its review to 'the pleadings themselves."' Dimitrakopoulos v. Borris, Goldin, Foley, Vignuolo, Hyman and Stahl, P.C., 237 N.J. 91, 108 (2019). If the court considers evidence beyond the pleadings in an R. 4:46(e) motion, then "that motion becomes a motion for summary judgment, and the court applies the standard of Rule 4:46." Ibid.

Both parties have submitted unpublished decisions of other courts as exhibits outside the pleadings. An unpublished opinion does not constitute precedent nor is it binding upon on this court unless it is required to be followed by reason of res judicata, collateral estoppel, the single controversy doctrine, or similar principle of law. R. 1:36-3. Neither party has proffered to the court that the unpublished opinion need to be considered by reason of the foregoing exceptions, nor have they argued or evidence that they have conducted a diligent inquiry for cases contrary to their position and have found none or that the cases that were located are distinguishable. Accordingly, this court does not consider the unpublished cases cited by both parties with respect to the motion pursuant to R.1:36-3. Since the court is not considering any exhibits other than the plaintiff's complaint, the motion shall be analyzed under the standard set forth above to be applied to a motion to dismiss.

The above captioned litigation arises from an action seeking reimbursement for medical services provided by plaintiff to a patient identified as "Patient M.R." The factual predicate for the motion is contained in plaintiff's complaint and is set forth

in relevant part as follows.

Plaintiff is a medical practice specializing in neurological treatment and procedures of the brain and spinal cord (Id. ¶ 1). Defendant PC is Patient M.R.'s employer (Id. at ¶ 3). Patient M.R. was a participant covered under a plan of medical benefits administered by defendant IC on behalf of defendant PC ("the "Plan") (Id. at ¶ 2).

Patient M.R. was admitted to The Hackensack University Medical Center ("HUMC") through its Emergency Department with acute lumbar radiculopathy and a herniation. (Id. at ¶ 13). Plaintiff and HUMC had Patient M.R. complete forms identifying his insurance coverage (Id. at ¶ 23). Plaintiff alleges that "defendants, directly or via their agent, issued pre-authorization relating to the hospital and treatment of Patient M.R." (Id. at ¶ 14.) Plaintiff asserts that it relied on "defendants' conduct and/or representations, including via the 'MagnaCare' logo [on his insurance card] … which conveyed that at a minimum plaintiff would be reimbursed reasonably consistent with past experience with the MagnaCare program." (Id. at ¶ 15.) On August 14, 2018, plaintiff provided surgical and related medical services to Patient M.R., namely a laminectomy, partial facetectomy and discectomy (Id. at ¶ 13). After completing the surgical procedure, plaintiff subsequently filed a claim for benefits with defendant IC in the amount of $57,200.00 (Id. at ¶ 25).

***2** The CPT Codes used to identify the services rendered by plaintiff to Patient M.R. was 63030 ($53,000.00) and 69990 ($4,200.00) (Id. at ¶ 19). By way of an Explanation of Benefits ("EOB") dated January 16, 2019, defendant IC denied plaintiffs claim for reimbursement in its entirety (Ex. A at ¶ 19).

Plaintiffs complaint contains the following causes of action: 1) breach of implied contract (First Count); 2) breach of the covenant of good faith and fair dealing (Second Count); 3) unjust enrichment and quantum meruit (Third Count); 4) promissory estoppel (Fourth Count); 5) negligent misrepresentation (Fifth Count); 6) tortious interference with economic advantage (Sixth Count); 7) violations of New Jersey regulations governing payment for emergency services rendered by an out-of-network provider (Seventh Count); and 8) violations of the New Jersey Healthcare Information Networks and Technologies Act ("HINT") and the Health Claims Authorization Processing and Payment Act ("HCAPPA") (Eighth Count).

Defendants argue that the causes of action in plaintiffs complaint must be dismissed since they are state law claims that are preempted by the Employee Retirement Income Security Act ("ERISA") of 1974. Plaintiff counters that its claims are beyond the reach of ERISA, which only applies to a subset of health law disputes and that it has pled valid *prima facie* claims.

Having considered the submissions of the parties and the oral argument of counsel, the court denies defendants' motion to dismiss for the reasons that follow.

ERISA Preemption

The Employee Retirement Income Security Act ("ERISA"), 29 U.S.C.A. § 1001 et seq., is a comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans by setting various uniform standards, including rules concerning reporting, disclosure, and fiduciary responsibility, for both pension and welfare plans. Finderne Management Co., Inc. v. Barrett 355 N.J. Super. 170, 185. (App. Div. 2002).

There are two types of preemption established under ERISA: complete preemption under Section 502(a) and express preemption under Section 514(a), which preempts state law claims that "relate to" an ERISA plan. St. Peter's Univ Hosp. v. New Jersey Bldg. Laborers Statewide Welfare Fund, 431 N.J. Super. 446, 455 (App. Div. 2013).

ERISA's civil enforcement mechanism, § 502(a), "is one of those provisions with such extraordinary pre-emptive power that it converts an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule," and permits removal. Aetna Health v. Davila, 542 U.S. 200, 209 (2004). A claim is completely preempted, and thus removable, under ERISA § 502(a) only if: (1) the plaintiff could have brought the claim under § 502(a); and (2) no other independent legal duty supports the plaintiff's claim. Pascack Valley Hosp. Inc. v. Local 464A UFCW Welfare Reimbursement Plan, 388 F.3d 393, 400 (3d Cir. 2004). Because the test is conjunctive, a state-law cause of action is

completely preempted only if both of its prongs are satisfied.

Defendants contend that ERISA preempts all claims in this suit because the employee benefit plan at issue was formed under ERISA.

Section 502(a) of ERISA allows "a participant or beneficiary" to bring a civil action, *inter alia*, "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C.A. § 1132(a)(1)(B). Standing under the statute is limited to participants and beneficiaries. With respect to the term, "participant," the United States Supreme Court has opined that the term 'participant' may be construed as "either 'employees in, or reasonably expected to be in, currently covered employment,' or former employees who 'have … a reasonable expectation of returning to covered employment' or who have 'a colorable claim' to vested benefits." Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 117 (1989). "Beneficiary" is defined as "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." 29 U.S.C.A. § 1002(8).

***3** Here, plaintiff New Jersey Brain and Spine P.C. is a neurological medical practice that has sought to recover fees for services rendered under the alleged terms of a provider agreement. Plaintiff is suing in its direct capacity— not suing as an assignee of the beneficiary— alleging that it performed emergency, preauthorized surgical services for the patient insured. Plaintiff does not allege that it is a participant, or a beneficiary as defined under Section 502(a). As such, the court finds that complete preemption under Section 502(a) is inapplicable here as plaintiff lacks standing to sue under that portion of the ERISA.

Further, Section 514(a) states that the ERISA shall supersede any and all state laws insofar as they relate to any employee benefit plan covered by the statute. 29 U.S.C.A. § 1144(a). ERISA preemption applies where a state law has a connection with or references to an employee benefit plan. St. Peter's Univ Hosp., supra, 431 N.J. Super. at 455. The term "state law" includes all laws, decisions, rules, regulations, or other state action having the effect of law. 29 U.S.C.A. § 1144(c)(1). A law "relates to" an employee benefit plan if it has a connection with or reference to such a plan. Id

However, notwithstanding its breadth, there are limits to ERISA's preemption clause under Section 514(a). Id. Preemption does not occur if the state law has only a tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability. Id Further, a state law claim may relate 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.

In Finderne, the Appellate Division found that the ERISA did not preempt negligence and common law fraud claims against insurance agents who made misrepresentations involving the tax consequences of benefit plans to induce the plaintiffs to purchase life insurance. Finderne Management Co., Inc., supra, 355 N.J. Super at 179. The claims involved "preplan misrepresentations" and did not "require an examination of the particulars of an ERISA plan." Id. at 193. The Appellate Division found that an ERISA plan would be "peripheral" and the duties involved in the case were outside the ERISA context. Id. at 195.

The Court in Finderne outlined four types of laws that "relate to" a benefit plan for purposes of ERISA preemption: 1) those that regulate the type of benefits or terms of ERISA plans; 2) those that create reporting, disclosure, funding or vesting requirements for the plans; 3) those that provide rules for calculating the amount of benefits to be paid under the plans; and 4) those that provide remedies for misconduct growing out of the administration of the plans. Id. at 190. In examining the effect of a state law on an ERISA plan, factors generally considered include whether the state law negates an ERISA plan provision, affects relations between primary ERISA entities, impacts the structure or administration of ERISA plans or has an economic impact on ERISA plans. Id Other factors are whether preemption of the state law is consistent with other ERISA provisions and whether the law is an exercise of traditional state power. Id. Where a plaintiff's claim arises directly from the administration of an ERISA plan, ERISA preemption is warranted. Id. at 195.

Here, plaintiff asserts that this is not a dispute as to coverage, but over the "quantum of reimbursement under state common and statutory law." To that end, plaintiff reasons that the court need not scrutinize the terms of the alleged ERISA plan, but

rather analyze defendants' direct representations and course of conduct with plaintiff in accordance with industry standard and custom. Plaintiff contends that there is no preemption where state law claims arise from implied and quasi contract causes of action and from an insurer misrepresenting the amount or availability of healthcare benefits during the pre-authorization process. Furthermore, plaintiff relies on Memorial Hospital System v. Northbrook Life Ins. Co., supra, 904 F.2d 236 (5th Cir. 1990) to argue that defendants' alleged negligent misrepresentations as to coverage available to a plan subscriber forms the predicate for plaintiff's right to pursue this claim.

***4** In St. Peter's Univ. Hospital v. New Jersey Bldg. Laborers Statewide Welfare Fund, 431 N.J. Super. 446, 455 (App. Div.), certif. denied, 216 N.J. 366 (2013), the Appellate Division found that a plaintiff hospital's complaint against a welfare fund seeking additional remuneration was preempted. St. Peter's Univ. Hospital, supra, 431 N.J. Super. at 446. The parties had completed discovery, and the Appellate Division concluded that the claims dealt directly with payment of benefits under the plan and involved more than a peripheral reference to the plan. That is, the court determined that it would need to examine and consult the terms of the ERISA plan to adjudicate the hospital's claims and assess "whether the benefit was covered, the amount of the copayment, the amount of the deductible, whether the plan was primary and secondary and whether Medicare coverage is available for purposes of the coordination of benefits, and the cap on benefits to calculate the benefit due the Hospital." Li at 460. To adjudicate plaintiff's claim, the court would be required to examine and interpret the terms of the ERISA plan in determining if an additional benefit was payable. Li Accordingly, the court found that the claim was not tenuous or peripheral. Id. at 460-461.

This court also recognizes that there is a presumption against preemption and that it is presented with a fact-sensitive issue. At this stage of the litigation, under R. 4:6-2(e), the Court accepts as true all facts pled in the complaint and searches in depth and with liberality to determine if a cause of action can be gleaned even from an obscure statement. Printing Mart at 772.

Thus, the court finds that dismissal on preemption grounds is premature and at this juncture, it cannot determine whether plaintiff's state law claims, are preempted by ERISA. Plaintiff has asserted that the alleged existence of an ERISA plan is not the subject of this litigation, nor is it a "critical factor" in establishing defendants' liability. The court requires a fully developed factual record to determine whether plaintiff's claims bear only a "tenuous, remote, or peripheral connection" to the alleged ERISA-covered plan, or whether, as in St. Peter's Univ. Hosp, the plan is directly connected to the claims asserted. As such, the court denies defendants' motion to dismiss plaintiff's complaint on preemption grounds without prejudice subject to renewal as a motion for summary judgment at the conclusion of material discovery.

Next, the court considers defendants' arguments that plaintiff has not stated any claim under New Jersey law upon which relief can be granted. As required by Printing Mart-Morristown, 116 N.J. 739, the court examines the factual allegations in the complaint with liberality.

Count I: Breach of Contract

In Count I, plaintiff alleges that defendants indicated that they would pay for the surgical and medical services that were provided, including the emergency services provided by plaintiff to defendants' insured Patient M.R. and that this is supported by a way of the Explanations of Benefits statements ("EOBs") and summary plan documents issued to plaintiff and Patient M.R. Plaintiff further alleges that it obtained pre-authorization by defendants' agent MagnaCare to perform operative procedures on Patient M.R., even though MagnaCare's website states that pre-authorization is not required for emergent services.

An implied contract consists of an obligation arising from mutual agreement and intent to promise but arises where the agreement and promise have not been expressed in words. When looking for mutual assent, a court will take these outward expressions and determine "what meaning the words should have conveyed to a reasonable person cognizant of the relationship between the parties and all of the antecedent and surrounding facts and circumstances." Esslinger's Inc. v. Alachnowicz, 68 N.J. Super. 339, 344, (App.Div.1961).

The court discerns an allegation of mutual assent from the complaint through plaintiff's allegations regarding the parties'

conduct, particularly the alleged preauthorization granted by MagnaCare, an agent of defendants, for plaintiff to deliver emergent care to Patient M.R.. Further, the court accepts as true plaintiff's allegation that defendants represented to the public, including NJ providers, that the allowed amount is "the maximum reimbursement the member's health plan allows for a specific service out of network. This amount may be … an allowance established by law." Plaintiff alleges that it was legally required under applicable New Jersey statutes and regulations to perform the required emergency services on defendants' insured. Thus, plaintiff reasonably expected defendants to compensate plaintiff at the emergency law or UCR rate.

***5** Additionally, plaintiff alleges that defendants would hold their insured harmless based on advertising that they have "a wealth of providers… [and that] MagnaCare offers access to a wide range of participating providers in all specialties...." The court accepts as true for purposes of this motion that defendants' summary plan documents to its insured provided that "benefits will be paid on the same basis as if you or your Dependent had used a Network provider… the Plan will negotiate the reimbursement amount so that there is no out-of-pocket expense to the Participant.."

The court finds the complaint alleges a flow of consideration to defendants in connection with the implied contract as to the disputed patient account. Defendants were legally obligated under federal and state laws to cover subscribers for emergency services and acknowledged such obligations. Plaintiff alleges in the complaint that by providing out-of-network emergency and/or preauthorized services to the defendants' insureds/beneficiaries, the plaintiff enabled the defendants to satisfy contractual or legal obligations to those individuals.

As such, the court finds that plaintiff's pleading alleges facts which form the basis of the elements of an implied contract including consideration and a claim for breach thereof.

Count II: Breach of Covenant of Good Faith and Fair Dealing

An implied-in-fact contract, under New Jersey law, contains an implied covenant of good faith and fair dealing. The "test for determining whether the implied covenant of good faith and fair dealing has been breached is as follows: a party exercising its right to use discretion…under a contract breaches the duty of good faith and fair dealing if that party exercises its discretionary authority arbitrarily, unreasonably, or capriciously, with the objective of preventing the other party from receiving its reasonably expected fruits under the contract." Wilson v. Amerada Hess Corp., 168 N.J. 236, 251 (2001). The covenant is breached "if a party uses its discretion for a reason outside the contemplated range - a reason beyond the risks assumed by the party claiming the breach." Id at 246.

Specifically, plaintiff alleges in the complaint that prior to filing formal legal action, and to avoid balance billing the patient, plaintiff, and its representatives, engaged in telephonic communications with defendants' representatives and/or agents appealing the claims at issue in this litigation. In addition, plaintiff through Patient M.R. appealed and that multiple times between February 2019 and January 2020 appeals were made via the patient's HR department to the plan administrator. Defendants were alleged to be non-responsive.

Here, the court accepts as true plaintiff's allegation that defendants had arbitrarily or unreasonably prevented it from receiving reasonably expected fruits under contract and then ignored plaintiff's attempts to try to resolve the dispute and avoid formal legal action. As such, the court finds that plaintiff has sufficiently pled a claim for breach of the covenant of good faith and fair dealing.

Count III: Unjust Enrichment and Quantum Meruit

The elements of a claim for unjust enrichment are that the defendant received a benefit and that retention of that benefit would be unjust. Castro v. NYT Television, 370 N.J. Super. 282, 299 (App. Div. 2004). Likewise, a claim for quantum

meruit arises when a party confers a benefit on another with the reasonable expectation of payment for the same.

Here, the court finds that the pleadings allege sufficient facts concerning a benefit conferred on defendants and a reasonable expectation that it would be paid. The complaint alleges that defendants represented to Patient M.R. that he had benefits for out of network emergency and/or pre-authorized care and that the patient may go to any hospital emergency room, and that defendants required the trauma care to satisfy the medical needs of defendants' insured. Thus, the court finds that plaintiff has adequately pled that defendants have enriched themselves unjustly at the expense of plaintiff who provided services and had a reasonable expectation that it would be paid for those services.

Count IV: Promissory Estoppel

***6** A claim for promissory estoppel requires a showing of a clear and definite promise made with the expectation of reliance, reasonable reliance, and substantial detriment. Lobiondo v. O'Callaghan, 357 N.J. Super. 488, 499 (App. Div. 2003).

Here again, the facts set forth in the complaint considered in their totality establish a cause of action for promissory estoppel. Plaintiff alleged defendants promised to pay for out-of-network or emergency services delivered and that defendants gave prior authorization for the services or advised that such authorization was unnecessary. Accordingly, the complaint sufficiently alleges that the result of such communication was a promise to pay for the services and that plaintiff relied on the communication to its detriment.

Count V: Negligent Misrepresentation

A plaintiff pursuing a claim for negligent misrepresentation must establish the negligent provision of information, that the plaintiff was a reasonably foreseeable recipient of such information, reasonable reliance on the false representations, and that the false statements caused damages. McCall v. Metropolitan Life Ins. Co., 956 F. Supp. 1172, 1186 (D.N.J. 1996).

Plaintiff alleges in the complaint that the defendants misrepresented the requirement as to the pre-certification of the treatment, and whether same was needed for the services rendered by plaintiff. Plaintiff also alleges that MagnaCare pre-authorized the services even though its website deemed that preauthorization was unnecessary for emergent services. Further, it is alleged that defendants represented to their insured and to their providers that they would hold the insured harmless for billed charges or UCR amounts to the extent required by law. Accordingly, the court finds that plaintiff adequately alleges that it reasonably relied on these assurances by providing Patient M.R. with the emergent services with an expectation that it would be paid and, therefore, the complaint states a cause of action for negligent misrepresentation.

Count VI: Interference with Economic Advantage

To state a claim for tortious interference with prospective economic advantage, a plaintiff must allege a protected interest, including a prospective economic relationship or contract, malice - defined as an intentional interference without justification - and a reasonable likelihood that the interference caused the loss of the prospective gain and damages. Printing Mart-Morristown, 116 N.J. at 751.

Here, the prospective economic advantage alleged is the future payment deriving from the provider/patient relationship and the patient/insured of the defendant, Patient M.R., who sought treatment from plaintiff. To the extent that a claim for tortious interference with prospective economic advantage cannot be maintained by a party to a contract, the court concludes that at this juncture the pleading is at minimum a sufficient pleading in the alternative should plaintiff's contract claims fail based upon the inability to establish the existence of a contract. Thus, the court concludes that a *prima facie* claim for tortious

interference can be gleaned by defendants' alleged preauthorization of the services to be rendered or MagnaCare's acknowledgement that same was not required for emergency services, followed by defendants' failure to pay the reimbursement at issue.

Counts VII and VIII: Private Rights of Actions under New Jersey Law

***7** Counts VII and VII contain claims asserted as implied private rights of actions under applicable New Jersey statutes and regulations pertaining to the provision of emergency services to patients and "Prompt Pay" laws and promulgated rules.

In Count VII, plaintiff alleges a private right of action for violations of New Jersey regulations governing payment for emergency services rendered by an Out-of-Network Provider pursuant to N.J.S.A. 26:2H-18.64. In Count VIII, plaintiff alleges an implied private cause of action under the Healthcare Information Networks and Technologies Act and the Health Claims Authorization, Processing and Payment Act and their regulations.

The Supreme Court of New Jersey held in R.J. Gaydos Ins. Agency, Inc. v. Nat'l Consumer Ins. Co., 168 N.J. 255, 277 (2001) that "New Jersey courts have been reluctant to infer a statutory private right of action where the Legislature has not expressly provided for such action. Id. To determine if a statute confers an implied private right of action, courts consider whether: 1) plaintiff is a member of the class for whose special benefit the statute was enacted; 2) there is any evidence that the Legislature intended to create a private right of action under the statute; and 3) it is consistent with the underlying purposes of the legislative scheme to infer the existence of such a remedy. Cort v. Ash, 422 U.S. 66, 95 (1975). These factors were adopted by the Supreme Court of New Jersey in In re State Comm'n of Investigation, 108 N.J. 35, 41 (1987). Although courts give varying weight to each one of those factors, "the primary goal has almost invariably been a search for the underlying legislative intent." Jalowiecki v. Leuc, 182 N.J. Super. 22, 30 (App. Div. 1981).

As the cited regulations and authorizing statutes do not provide an express right of action, the court must consider whether plaintiff is the intended beneficiary of the statue or rule, whether there is indicia of legislative intent to establish a private right of action, and whether an implied private right of action advances the statutory regulatory objectives.

With respect to the seventh count, applicable New Jersey law and regulations require that providers render emergent care to all patients, regardless of their ability to pay, or the source of payment. N.J.S.A. 26:2H-18.64. In addition, payors are required to specifically notify their subscribers that they are entitled to have "access" to emergency services, and "payment of appropriate [health] benefits" for emergency conditions "24 hours a day" and "seven days a week." N.J.A.C. 11:24A-2.5(b)(2). An insurer is required to pay one-hundred percent (100%) UCR fees, less the patient's applicable copay, coinsurance or deductible for all patients admitted through the hospital emergency room, pursuant to N.J.A.C. 11:22-5.8, 11:24-5.3, 11:24-5.1, and 11:24-9.1(d). These regulations specifically requires "carriers" to reimburse "hospitals and physicians" for all medically necessary emergency and urgent care covered under the health benefit plans in circumstances where the member cannot reasonably access in-network services.

Plaintiff alleges a private right of action under New Jersey rules requiring that an out-of-network provider be paid a large enough amount to ensure that the patient is not balance billed, that is, charged for the difference between the insurer reimbursed amount and the provider's billed charges. Plaintiff alleges that defendants are obligated to pay the UCR charges for such emergency services, less applicable co-pay, coinsurance or deductible.

***8** The court concludes that plaintiff is arguably the intended beneficiary of the regulation. The cited rule clearly requires the insurer to pay the full UCR costs for emergency services to the hospitals and physicians who rendered care for their insured. In addition, the purpose of the cited regulations is to "set forth the minimum standards which carriers, as defined at N.J.A.C. 11:24A-1.2, must meet in order to be in compliance with the requirements of the Health Care Quality Act." Further, the rules "set standards for the payment of claims relating to health benefit plans and dental plans." N.J.A.C. 11:22-l. 1. Thus, the court finds that the purpose and scope of the rules is intended to protect the interests of medical providers seeking reimbursement of unreimbursed costs for providing emergency services and implies a right of action to obtain a required reimbursement. Accordingly, the court concludes that the complaint states a *prima facie* case for private right of action for plaintiff as to the

costs associated with providing emergency services to Patient M.R.. Should the facts set forth in the complaint not be borne out through discovery as set forth by plaintiff, defendants may file the appropriate dispositive motion after the completion of material discovery.

The eighth count alleges an implied private cause of action under the Prompt Pay laws and regulations adopted in New Jersey. Pursuant to the Health Information Networks and Technologies Act N.J.S.A. 17B:30-23, 17:48-8.4, 17:48A-7:12, 17:48E-10.1, 17B:26-9.1, 17B:27-44.2 and 2-26:2J-8.1 and implementing rules at N.J.A.C. 11:22-1 et seq., an insurer is required to remit payment to a medical provider for an "eligible" non capitated claim for medical services no later than thirty (3) calendar days following electronic receipt of the claim by Defendants. In the alternative, an insurer is required to notify the provider within seven (7) calendar days of the specific reasons for a denial or dispute, and to expeditiously request any missing information or documentation required to process the claims, pursuant to the Health Claims Authorization, Processing and Payment Act ("HCAPPA"). N.J.S.A. 17B:27-44.2 specifically provides that an overdue payment shall bear simple interest at a 12 percent per annum rate. It further provides that "interest shall be paid to the healthcare provider at the time the overdue payment is made" and further provides that any such amount actually paid shall be credited to any civil penalty assessed for a violation.

Specifically, plaintiff alleges that defendants were obligated to pay or contest the insured's claims within the given time periods and failed to do so. In addition, plaintiff alleges that the overdue payments bear simple interest at the rate of twelve (12) percent per annum, pursuant to HCAPPA.

The court finds plaintiff has set forth *a prima facie* showing that it is in the category of intended beneficiaries which the statute intended to protect. The statutory text contemplates not only a scheme for an insurer's payment of eligible claims to a medical provider for medical services, but also the payment of interest for delays directly to the provider and thus the right of the provider to charge and recover the same. A private right of action would advance the interest of prompt payment of uncontested statements and billing disputes.

The Court, having considered the submissions, denies defendants' motion to dismiss the complaint.

Christine M. Vanek /s/ <<signature>>

Christine M. Vanek, JSC

4/12/2021

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