2024 WL 3184165 (N.J.Super.L.) (Trial Order)
Superior Court of New Jersey, Law Division,
Civil Part.
Essex County

ATLANTIC SHORE SURGICAL ASSOCIATES, PC, Plaintiff,
v.
AMERIHEALTH INSURANCE COMPANY OF NEW JERSEY; Amerihealth HMO, Inc.; and ABC Corps. 1-100, Defendants.

No. ESX-L-2195-23.
June 21, 2024.

***1** (Heard telephonically)
Date: May 8, 2024

**Transcript of Decision**

Eric D. Katz, Esq., (Mazie Slater Katz & Freeman, LLC), for the plaintiff.

Leslie Greenspan, Esq., (Tucker Law Group), Transcriber, Christina Gmiterko, G & L Transcription of NJ, 330 Changebridge Road, Suite 101, Pine Brook, NJ 07058, www.gltranscriptsnj.com, transcripts@gltranscriptsnj.com, Audio Recorded, Recording Op., Aliyah Bateman, for the defendants.

Annette Scoca, Judge.
Honorable Keith E. Lynott, Judge

TRANSCRIPT ORDERED BY:

SHANNON GREEN, (Thomson Reuters)

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None

**Colloquy**

THE COURT: May 7th (sic). It is Atlantic Shore Surgical Associates P.C. v. AmeriHealth Insurance Company of New Jersey and the AmeriHealth HMO, Inc.

This matter is docketed at L-2195-23.

And at this time, the Court is going to provide the parties with an oral bench ruling on a long-pending motion to dismiss, in part, the Plaintiff's complaint.

They are proceeding utilizing a dial-in conference call with counsel for the respective parties both participating remotely on the phone. And I have connected that call now to the courtroom recording system. So we are now on the record.

Good afternoon to council. Would you enter your appearances, please?

MR. KATZ: Good afternoon, Your Honor. Eric Katz of the law firm of Mazie Slater Katz & Freeman on behalf of the Plaintiff.

MS. GREENSPAN: Good afternoon, Your Honor. Leslie Greenspan from the Tucker Law Group on behalf of the Defendants.

THE COURT: Okay, anyone else here?

All right, just a bit of logistics or ground rules. I'm going to provide a fairly lengthy opinion here. It will take some time to go through.

**Decision**

I will ask just for the purpose of maintaining a clear, unobstructed connection to the recording system that council mute your cell phone connection and silence your phones or connections while I'm speaking.

Once again, just to keep the line clear.

Obviously, if there's any interruption in the connection or you have any problems hearing me for any reason, whatever that might be, don't hesitate to unmute, interrupt, let me know that, and we'll stop and take the necessary action to restore the connection with whatever is necessary at the time.

As you probably know there are frequently emergency vehicles that pass by the courthouse here. So if something like that happens, I might stop the proceedings and allow the vehicle to pass.

I recognize that the case is going to proceed from here regardless of the disposition of this motion, as it's a partial motion to dismiss in part. And I'm well aware that the case — because of the long Pendency of this motion — has been inactive for a long time.

  

So once the parties have the results of this motion, we'll have a case management conference and (indiscernible) fast forward in a sensible process for the party to take the discovery they wish to have to pursue the action on the defenses thereto.

As I said, this will take a bit of time.

I presume one party or the other will wish to have and will keep a transcript.

And in any event, no one is required to remain here if you don't wish to, or if you've heard what you wanted to hear or whatever the case may be. So there's no need to ask the court for any type of leave to leave the platform. Just feel free to do so, if you choose to do so.

***2** So with that overall background, I'll proceed as follows.

Once again, don't hesitate to let me know if you have any difficulty hearing what I'm saying.

The matter, once again, is Atlantic Shore Surgical Associates PC v. AmeriHealth Insurance Co. of New Jersey and AmeriHealth HMO, Inc.

I'm going to refer henceforth to the Plaintiff as Atlantic Shore Surgical Associates PC as Atlantic and collectively AmeriHealth Insurance Co. of New Jersey and AmeriHealth HMO Inc and AmeriHealth. The action, once again, is docketed as L-2195-23 on the complex docket.

The motion pending before the Court is the motion brought by the Defendants, AmeriHealth.

They are seeking to dismiss the complaint in part. I'll describe the actual application shortly, pursuant to rule 4:6-2(e) failure to state a claim.

As this is a motion for failure to state a claim, the applicable standard of review for the Court to apply in considering the motion is amply set forth in a number of cases, but in particular Printing Mart Morristown Inc. V. Sharp Electronics Corp. at 116 New Jersey — excuse me — 739, 746 1989.

The Court is required to determine, insofar as dismissal is sought of various counts of the complaint, the legal sufficiency of those counts of the complaint, and specifically, to determine whether a viable cause of action is or are suggested by the facts.

As the *Printing Mart* Morristown Court (indiscernible) the court examines the record rigorously to determine whether it is possible to discern the "fundament" of a cause of action from even a "obscure statement" of claim.

In examining a motion to dismiss, the Court is not concerned with the plaintiff's ability to prove the facts that are alleged in the complaint.

Indeed, it must accept as true the factual (indiscernible) of the complaint, although in that regard the Court is not required to accept as true facts — legal conclusions that are stated as facts and/or bold from supported factual assertion.

The Court is also required to confer on the Plaintiff the benefit of all inference that may reasonably be drawn in its favor from the factual (indiscernible) of the complaint.

As this was a complaint that in one respect alleges negligent misrepresentation, Rule 4:5-8 is also applicable to the Court to the substance of the sufficiency of the pleadings that will impose a heightened standard of pleading for causes action asserting misrepresentation or fraud.

It requires that the Plaintiff pleads specific facts generally as to the who, what, where and when of these alleged misrepresentations.

But to the extent practicable, the Court is also permitted to allege facts going to intent, and so forth on a general basis. Although, as the claim sounds in negligent misrepresentation, that principle is not directly operative here.

The Court draws the facts relevant to the disposition of this motion from the complaint itself and the Court accepts as true, solely purposes of adjudicating this motion, the factual averments set forth in the complaint as follows:

The Plaintiff, Atlantic, is a medical practice which practices or maintains offices in New Jersey and specializes in surgical treatment, including general and bariatric surgery.

***3** The Defendant, AmeriHealth, collectively, are entities with offices in New Jersey and provide health coverage to ensure that these defendants either underwrote and/or administered.

The complaint also identifies as fictitious parties ABC Corps 1 through 100 that are, at present, unidentified that are described in the complaint as parties that consist of plans providing health, medical, and hospital coverage to their members and/or their dependents, including the patients identified in this action. And/or are administrators providing such coverage which the complaint alleges provides hospital and medical coverage or administrative services in New Jersey for out of network services, including emergency services and/or pre-approved services to patients of the Plaintiff.

The complaint alleges that the Plaintiff, Atlantic, was and at the relevant time, an out of network or non-participating healthcare provider in relation to the Defendant.

The Plaintiff has set forth in its complaint what it refers to as a disputed claim list, or a DCL, which is how I will refer to it hereinafter, that sets forth or identifies the patients at issue and the claims at issue in this action, including the factual basis for additional payment from the defendants for the services rendered by Atlantic Physicians.

Each entry in the DCL identifies the patient by initials, identifies the AmeriHealth ID number, identifies the date or period of service, identifies the amount claimed to be owed, and contains a column described as basis, which generally, although the entries differ from entry to entry, describe the nature of the patient's condition and generally asserts that the condition required hospital emergency department admission.

And alleges underpaid emergency surgery under a preauthorization reference number that is either set forth in some cases or that is said to be sought in the course of discovery.

In one instance, the patient (indiscernible) for the patient T.H., there's a somewhat different allegation which is set forth in the basis column which (indiscernible) that AmeriHealth, via an agent identified as the (indiscernible) and the Plaintiff entered into a payment agreement to revolve the bill's claims for a specified amount and alleges that the agreement has been breached as only partial payment was made.

The Plaintiff alleges that the Defendants issued telephonic pre-authorizations relating to the claims that issued on the DCL.

It asserts that the Plaintiff relied on and was induced, in part, to render services with the expectation that it would be reasonably compensated consistent with the "usage of trade laws of the state of New Jersey. Statements representations and conduct of defendants."

The complaint alleges that AmeriHealth and the other defendants, which I take to be referring to the fictitiously named defendants, knew or should have known that,

> "Under the laws of the State of New Jersey, the patients must be held harmless when emergency services are rendered and thus defendants must pay Atlantic 100% of Plaintiffs billed usual, customary and reasonable, defined as UCR charges, less the patient's copay, coinsurance or deductible, if any, under New Jersey law."

***4** Citing specifically to N.J.A.C. 11:22-5.8, 11:24-5.3, 11:24-5.1, AND 11:24-9.1D, which is defined in the complaint as the emergency room mandate.

  

The complaint alleges that a UCR fee is the amount that out of network providers, such as the Plaintiff, normally charge for patients in the free market.

That is, without agreement with an insurance company or other payor to reduce such charge in exchange for obtaining access to the Defendant's members and dependents.

The complaint alleges that the UCR fee means the reasonable charge for a particular service by providers,

"In the same geographic area and with similar training and experience (i.e., Central New Jersey Surgical Practice.)"

Footnote omitted.

Complaint alleges that AmeriHealth and the other defendants knew or should have known that under the laws of the State of New Jersey, specifically citing the Healthcare Information Network and Technologies Act or HINT. N.J.S.A. 17B:30-23, 17:48-8.4, 17:48A-7.12, 17:48E-10.1, 17B — 17B:26-9.1. I should have said 17:48E-10.1, 17B:27-44.2, and 26:2J-8.1, and corresponding regulations at N.J.A.C. 11:22-1.

Defendants are required to remit payment to a healthcare provider for an internal, "eligible" for non-capitated claim for medical services no later than 30 — the Number 30 — calendar days following electronic receipt of the claim by defendants or 40 — with the number 40 — calendar days following non-electronic receipt of the claim by defendants, and that all overdue payments must be — must be, it says — simple interest.

I presume that intended to mean bare simple interest at the rate of 12 percent per annum pursuant to the Health Claims Authorization Process and Containment Act, defined as HCAPPA, where the HINT and HCAPPA are collectively referred to as the Prompt Pay Law.

The Plaintiff avers that despite Defendant's knowledge of their lawful obligation relating to correct and timely payment of emergency services to Atlantic and with respect to the patients on the DCL, the Defendants ignored the emergent nature of Atlantic services, which it alleges included acute appendicitis, acute cholecystitis, and necrotic wounds. Thereby improperly exposing the patient to balance bills that greatly exceeds the correct patient responsibilities.

The complaint avers that Atlantic timely filed claims of defendants in accordance with timeframes set forth in New Jersey law. It asserts that Atlantic has submitted supporting documents to submit its request for payment to the Defendants and their agents. And that even though the services rendered by Atlantic were emergency and/or pre-approved medically necessary surgical care which it asserts are facts upon which the Plaintiff relied.

The Defendant's system,

"Systematically failed to issue proper reimbursement for the services rendered by Atlantic to the patients identified in the DCL."

Atlantic alleges IT has exhausted the administrative remedies provided by the Defendants and any related entities or agencies for the claims at issue in this action or that such remedies were futile.

It alleges that to avoid balanced billing of the patients identified on the DCL, it and its representatives engaged in communication with the Defendant's representative and/or agents regarding the claims at issue in the litigation prior to filing legal action, but the Defendants were non-responsive.

***5** Atlantic avers that the Defendants have failed to issue proper payment for the surgical and medical services rendered by the Plaintiff. Instead,

"Defendants issued gross under payment."

  

In making such payments, the Defendant's actions or inactions "were unlawful and improper because defendants failed to calculate the amount of the payment — "

With 'amount' underscored.

"And original in accordance with state statutory, regulatory and/or common law."

Atlantic avers that the claims in this action arise from state common, statutory, and regulatory law, and that none are predicated on any purported federal law, statute, or right.

Plaintiff avers that (indiscernible) asserting its own direct claims and causes of action rather than derivative claims predicated on an assignment of benefits from the patient.

Atlantic asserts that all the claims and causes of action asserted in this case arise under one or more independent duties "unfettered by any type of federal preemption", including the New Jersey prompt pay laws, statutes, and regulations providing :implied contractual duties and implied private rights of action to Plaintiff.

The New Jersey laws, statutes, and regulations governing the reimbursement of out of network providers rendering emergency services "providing implied contractual duty and implied private rights of action to Plaintiff".

And the pre-authorizations and/or pre-certifications and/or payment verifications provided by the Defendant, the Plaintiff — "to induce Plaintiff to render surgical and medical services with promise to proper payment."

The first count of the complaint, although not at issue in this motion, alleges a breach of implied contract.

> It asserts that the Defendants indicated, "By course — a course of conduct, usage of trade laws of the State of New Jersey, state insurance mandates, course of dealing, industry customs, and/or the circumstances surrounding the relationship to Atlantic, that Defendants would properly pay for surgical and medical services provided. Including the emergency services provided by Atlantic. The defendants' insureds identified in the DCL."

This count alleges that the Defendants represented in relation to the subject patients that their members and dependents are covered for out-of-network emergency and/or pre-authorized care and that they may go to any hospital emergency room when they need emergency care. And that they will only be responsible to pay the plans' co-payments, coinsurance, and deductibles at an in-network level when emergency services are rendered.

The Plaintiff alleges that the Defendants were paid premiums by the patients for out-of-network emergency health care coverage, and that the services provided by Atlantic to the patients identified on the DCL were, "necessary to satisfy the surgical and medical needs of Defendant's insured."

This count alleges that the defendant further indicated,

> "By a course of conduct, usage of trade, laws of the state of New Jersey, state insurance mandate, course of dealing, industry customs, and/or the circumstances surrounding the relationship to Atlantic that defendants would hold their insureds harmless and thus timely pay Plaintiff's billed charges or UCR amounts based on what other healthcare providers of the same specialty in the same geographic area charged for services rendered by Atlantic in accordance with state insurance mandates."

***6** The plaintiff alleges that the Defendants also indicated,

> "By a course of conduct, usage of trade, laws and the State of New Jersey, state insurance mandates, course of dealing, industry custom, and/or the circumstances surrounding the relationship, course of conduct to Atlantic that they would honor, inter alia, A, their representations of the services rendered were pre-authorized, and B, their indications that pre-authorization was not required."

  

Atlantic asserts that it rendered medically necessary surgical and medical services, including emergency services, to the patients identified in the DCL and reasonably expected the Defendant to properly compensate the Plaintiff.

In a search that despite indicating to Atlantic by a,

> "Course of conduct, usage of trade, laws of the State of New Jersey, State insurance mandates, course of viewing industry customs, and/or the circumstances surrounding the relationship, the defendants would properly and timely reimburse Plaintiff for either its actual charges as an out-of-network provider or its UCR rates. Defendants failed to do so."

Complaint asserts that the Defendant — it's the failure of the Defendants to pay the reasonable value of the Plaintiff's services,

"Constitutes breach of the implied contract between Defendants and Atlantic."

This count seeks or demands entitlement to compensatory damages, interest, cost of suit, and attorneys fees.

The second count which is at issue in this motion alleges or asserts a claim grounded in breach of the covenant of good faith and fair dealing.

This complaint alleges that the laws of New Jersey imply in every contractual relationship, including the contractual relationship between Atlantic and the Defendants, a covenant of good faith and fair dealing.

Atlantic avers that the Defendants acted with an improper motive and injured Plaintiff and,

"Injured plaintiff's rights and benefits under the contract and so breached the covenant through acts of commission and omissions described herein that are wrongful and without justification."

This count also seeks for claimant's entitlement to compensatory damages, interest, cost of suit, and attorney fees.

The third count, although not at issue in this motion practice, purports to assert a claim sounding in quantum meruit.

It avers that the Plaintiff performed and rendered medical services relating to the patients in this action in good faith.

> The plaintiff alleges that it, "Reasonably expected compensation for its services in accordance with pre-authorization, state insurance mandates, the respective course of conduct, usage of trade, laws of the State of New Jersey, course of dealing, industry custom, and/or the circumstances surrounding the relationship."

This count avers that the Defendants have profited themselves at the expense of Plaintiff's efforts and services unfairly, that at all relevant times, the Defendants refused to pay Plaintiff correctly for the medical services Plaintiff provided to the patients listed on the DCL contrary to New Jersey common law, statutory law, and regulatory obligations of the Defendants.

***7** And that the Defendants have been conferred a benefit by diverting payments that should have been paid to Atlantic to pay the Plaintiff — to pay themselves.

This count avers that to satisfy the defendant's legal obligations, including network adequacy obligations,

"The Defendants required the services of Atlantic to render the surgical and medical services."

Thus, according to the complaint, the Plaintiff conferred a benefit on the Defendants for this additional reason.

The Plaintiff alleges that the Defendants have therefore received and retained a benefit because of Atlantic rendering services

  

that remain,

"Grossly underpaid."

It avers that the Defendants have been enriched through the use of funds that earned interest or otherwise added to their profits when such funds should have been paid in a timely and appropriate manner to the Plaintiff and that the Defendant failed to,

"Compensate Plaintiff the reasonable value of the services."

This count, likewise, demands and claims entitlement to compensatory damages, interest, cost of suit, and attorney's fees.

The fourth count, albeit once again not directly — not implicated in this particular motion, purports to assert a claim sounding as promissory of estoppel.

In this count, the Plaintiff alleges that the Defendants,

> "Made promises to Plaintiffs that proper reimbursement for medical services would be afforded to the patients identified in this action, including by pre-authorizing services and/or advising that authorization was not necessary and/or in accordance with inter alia, usage of trade, laws of the State of New Jersey, and the State insurance mandate, but then refusing proper payment when the bills were submitted by Atlantic."

This count avers that the Defendant expected or reasonably should have expected that the pre-authorizations and/or insurance mandates, and/or laws of the State of New Jersey would be relied upon by Atlantic in rendering medical services needed by the patient.

Atlantic contends that in connection with the pre-authorization, the Defendants did not advise or disclose that after they rendered the pre-approved services,

"All claims would actually be paid at rates significantly less than those reasonably expected."

This count avers that the Plaintiff reasonably relied on the pre-authorization and was induced to render the services accordingly.

It avers that its reliance on the promises caused it to suffer a definite and substantial detriment and that contrary to Defendant's statements and obligations to properly pay for the services, the Defendants unilaterally imposed an extremely low rate of payment.

This count also alleges entitlement to compensatory damages, interest, cost dispute, and attorneys fees.

Fifth count, which is implicated by the present motion, purports to state a claim finding negligent misrepresentations.

> The Plaintiff avers that the Defendants, "Negligently represented that they would provide proper reimbursement to Atlantic with respect to the patients identified in this action, including but not limited to by way of pre-authorization, advising that pre-authorization was not necessary and/or in accordance with inter alia, usage of trade, laws of the State of New Jersey, and the State insurance mandates, but then refusing proper payment when the bills were submitted by Atlantic."

***8** The Plaintiff contends that it expected — or that the Defendants expected or reasonably should have expected that the pre-authorizations and/or State insurance mandates and/or laws of the State of New Jersey would be,

"Relied upon by Atlantic in rendering the medical services needed by the patient."

It asserts that Atlantic reasonably relied on the same to its substantial detriment.

This count avers that the representations were false,

> "Prominently, Defendants materially misrepresented to Atlantic that Plaintiff would be paid appropriately. However, after the services were rendered, and contrary to the pre-authorization and/or State insurance mandates and/or laws of the State of New Jersey, Defendants improperly underpaid for the services rendered."

The Plaintiff prays or demands compensatory — prays for or demands compensatory damages, interest, cost (indiscernible), and attorney's fees.

The sixth count, unimplicated by the pending motion, asserts a claim for tortious interference with economic advantage.

> It avers that the plaintiff had, "A reasonable expectation of economic advantage or benefit belonging to — belonging or accruing to Plaintiff. It avers that the defendants wrongfully interfered with Plaintiff's expectancy of economic advantage for benefit, that the Defendant's wrongful act — that because of the Defendant's wrongful act, it is reasonably probable that — but for the Defendant's wrongful act it reasonably probable that the Plaintiff would have realized its economic advantage or benefit resulting in damage."

This count prays for relief sounding in compensatory damages, punitive, and exemplary damages, interest, cost dispute, and attorney's fees.

The seventh count, which is implicated by the present motion, purports to state a claim grounded in violations of New Jersey regulations governing payments for emergency services rendered by an out-of-network provider.

It alleges that,

> "To ensure access to emergency care regardless of a patient's insurance, New Jersey insurance regulations mandate that payors determine coverage and pay promptly. Under this healthcare insurance regulatory regime, New Jersey law requires payors to specifically notify their subscribers that they are entitled to have 'access to emergency services,' and 'payment of appropriate health benefits' or emergency conditions '24 hours a day' and 'seven days a week'. Citing N.J.A.C. 11:24A-2.5(b)(2)."

This count alleges that pursuant to these New Jersey healthcare insurance regulations, when a privately insured patient seeks emergency services, an out-of-network provider,

> "Must 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. This so-called 'emergency room mandate' applies even if it means that the payor must pay the provider if actual bill charges, minus the copayments, coinsurance, and deductibles, if any, that would have applied had the patient sought treatment from an in-network provider." This count avers that the Plaintiff has a, "Private right of action expressed or implied to prosecute its claim under these regulations."

It asserts that the Defendants are obligated to pay Atlantic 100 percent of the Plaintiff's UCR fees, less the patient's applicable copay, coinsurance, or deductibles 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).

***9** This count alleges that the Defendants have not properly paid for emergency surgical and medical services rendered to the patients listed on the DCL. It asserts that violations of these health insurance regulations and related legal obligations have caused damage to the Plaintiff.

Atlantic claims entitlement pursuant to this count to compensatory damages, interest, cost dispute, and attorney's fees.

The eighth count, also implicated by this motion, alleges violations of a claim predicated on violations of New Jersey HINT and HCAPPA.

This count alleges that,

> "Pursuant to the Healthcare Information Networks and Technologies Act, or HINT, 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 26:2J-8.1, and the corresponding regulations, N.J.A.C. 11:22-1.
>
> Defendants are required to remit payment to a healthcare provider for an 'eligible' non-capitated claim for medical services no later than 30 calendar days following electronic receipt of the claim by Defendants or 40 calendar days following non-electronic receipt of the claim by the Defendants. In the alternative, defendants are required to know notify the provider within seven calendar days of the specific reasons for a denial or dispute and to expeditiously request any missing information or documentation required to process the claim pursuant to the Health Claims Administration Processing and Payment Act, or HCAPPA." Atlantic asserts it has a,

"Private right of action, expressed or implied, to prosecute its claims under HINT, HCAPPA, and their regulations."

It asserts that overdue payments must bear interest, simple interest, at a rate of 12 percent per annum pursuant to the HCAPPA.

It contends that,

> "By delaying payment of the claim, Defendants earned and continue to earn profits from their use of funds, profits they would not have earned or continued to earn if payment were made in a timely manner."

This count also claims entitlement to compensatory damages, interest, cost of suit, and attorney's fees.

The Defendant moved for dismissal of the second count of the complaint alleging breach of the implied covenant of good faith and fair dealing, a fifth count alleging negligent misrepresentation, and the seventh and eighth counts alleging implied private rights of action under New Jersey statutes and regulations dealing with claimed emergency room mandates and/or prompt payment of provider reimbursement claims.

In addition, the movant seeks to strike from every addendum clause in the complaint, any claim for (indiscernible) of attorney's fees.

The movant asserts the claims alleging breach of the covenant of good faith and fair dealing fails as a matter of law because the Plaintiff's pleading states or relies upon the same facts to establish that claim that they also assert in support of the claim for breach of implied contract in the first count.

They contend the absence of separate or different pleaded facts specifically supporting the claim for breach of the implied covenant of good faith and fair dealing is fatal to the right to simultaneously assert such a claim along with the claim for breach of contract.

The movant contends the Plaintiff has failed to plead the claim set forth in the fifth count as certain negligent misrepresentations of the required particularity. Citing to Rule 4:5-8, Specifically.

***10** The motion — movants argue that the count does not identify who made the alleged misrepresentation, what specifically was stated that constitutes a misrepresentation, and when the same was made.

They contend such facts, if they exist, would be within the possession of the Plaintiff.

  

The Defendants further assert that based on the allegations of the complaint, the Plaintiff could not possibly have relied on the alleged misrepresentations asserted at all, let alone could it have reasonably or justifiably relied on the same.

This is so, according to the movant, because the Plaintiff contends it performed emergency medical services for each of the patients.

In such circumstances, the movants argue, the Plaintiff's physicians would (indiscernible) have been required pursuant to legal requirements and ethical obligations of their profession to perform the necessary medical care regardless of whether they did or did not secure an authorization from a representative of the Defendant as alleged.

As a result, according to the movant, the averment of reliance on the Defendant's alleged misrepresentations, whether conveyed in word or by action, is directly at odds with the other facts pleaded by the Plaintiff.

The Defendants argue that the claims lodged in the seventh and eighth counts fail as a matter of law as there is no implied private right of action afforded to the Plaintiff by either the so called — by the Plaintiff emergency mandate laws or regulation or the prompt pay law.

In particular, they contend that the Plaintiff is a medical society or similar organization and that the Appellate Division in Medical Society of New Jersey v. AmeriHealth HMO, Inc., 376 N.J. Super 48 — 58-59, App. Div. (2015) explicitly declined to find such — that such a society could proceed under a theory of implied private right of action.

The Defendants seek a determination as a matter of law that the Plaintiff cannot recover attorney's fees from the Defendant as an element of relief in relation to any of the claims asserted by the Plaintiff.

They posit that a plaintiff may only recover attorney's fees — that is a shifting of the normal obligation of parties to bear their own council fees in civil litigation in New Jersey under the so-called American rule if such a fee shift is authorized by contract, statute, or court rule.

The Defendants argue the pleading does not allege facts establishing that the party's implied contract, even if such contract exists, provided for a fee shift in the event of a breach. Nor, according to the movant, can or does the Plaintiff point to any statute or rule that authorizes the fee shift in the circumstances alleged here.

Accordingly, the Defendants seek an order striking the prayers for attorney's fees in the various counts.

The Court finds that the Plaintiff has stated a viable claim for breach of implied — the implied covenant of good faith and fair dealing as the movants appear to acknowledge.

If the court finds an implied, intact contract between the parties, such contract would contain and imply in law covenants of good faith and fair dealing.

In examining the pleading, the Court is required by Printing Mart to scrutinize it rigorously and in its entirety.

***11** Thus, although the second count itself is conclusory in stating merely the elements of the claim, the court must examine the pleaded facts in their entirety to determine if such facts suggest a viable cause of action for breach of the covenant of good faith and fair dealing.

The plaintiff alleges that it secured from the Defendant, preauthorization for the medical services provided, or agreement or acknowledgement that such authorizations were unnecessary.

It asserts the Defendants were aware, due to course of dealing, industry customs, and/or statutory or regulatory prescription, or because of the authorizations themselves, that such authorizations imposed on them an obligation to pay the Plaintiff's billed charges for the services in sufficient amount to avoid balance billing of the patient.

Complaint alleges the preauthorization thus obligated the Defendants to pay the Plaintiff at the UCR rate to be determined properly according to accepted data and standards for determining UCR such as those available through Fair Health (phonetic).

The complaint alleges that, notwithstanding such mutual understanding, the Defendants grossly underpaid for the services.

The plaintiff avers that the Defendant willfully ignored or disregarded their obligations to pay the provider correctly via — to pay the provider correctly determined UCR rates in order to retain funds and enhance their own earnings.

The Court finds the pleaded facts, if proved, could result in a finding of breach of the covenant of good faith and fair dealing. That is, the exercise by the Defendants with their discretion in fixing the amount. Specifically, the appropriate UCR rates for the services provided of the reimbursement in a manner as to deprive the Plaintiff of the benefit of the bargain for its medical services.

Namely, reimbursement based on proper determination of UCR rates.

See Wilson v. Amerada Hess Corp., 163 N.J. 236, 251 (2001).

Whether the Plaintiff can prove such a claim is, of course, not a consideration at this junction.

The Court concludes that the Plaintiff has pleaded facts establishing a viable claim for a negligent misrepresentation.

See Karu v. Feldman, 119 N.J. 135, 146-147 (1990).

The Plaintiff alleging negligent misrepresentation must establish the negligent providing of false information, that the Plaintiff was a reasonably foreseeable recipient of such information, reasonable reliance, and resulting damages.

The Court concludes that the Plaintiff has stated facts establishing such a viable claim. This is so even considering the heightened pleading standard required by Rule 4:5-8.

The Court observes in this regard that this rule requires particularity where practicable.

The Plaintiff has pleaded misrepresentations by the Defendant in the form of pre-authorizations for medical services then rendered by the Plaintiffs.

The complaint identified the patient, the AmeriHealth ID number relating to the patient, and in many cases the AmeriHealth reference number relating to the authorization, the date of service, and the nature of the authorization given.

Despite the Defendant's assertion to the contrary, there is no reason to conclude that the Plaintiffs can, at this juncture, identify the specific representative of AmeriHealth who provided the authorization.

***12** As noted, the pleading alleges the authorization was given in circumstances in which the Defendants knew or reasonably should have known that the authorization required the Defendants to pay the Plaintiff's billed charges so as to avoid balance billing of the patients at UCR rates for — if the services were emergency — were emergency services, or as well as UCR rates if the services were pre- authorized non-emergency services.

It avers the Defendants understood, based on course of dealing, industry custom, and statutory and regulatory requirements that they are required to follow that this is so.

As a result, according to the complaint, issuing a pre-authorization or confirmation that no authorization was necessary in the circumstances is an assurance of payment at the UCR rate of which the Defendants were or should have been aware.

The pleading alleges the Plaintiff relied on this assurance at the time the services were to be provided. In then performing the medical services, and the Defendants knew or reasonably should have known that such reliance would ensue from such

authorization, it avers that the Defendant subsequently they grossly underpaid for the services, thereby rendering the assurances given by them as to payment false or untrue.

These allegations, including the information provided in — by the Plaintiff and the DCL establishes the elements for a claim with negligent misrepresentation and does so with requisite particularity as to the — as and to the extent practicable.

The pleading adequately notifies the Defendants of the essential facts and claims they are required to defend.

As to the issue of reliance, the Plaintiff pleads that it relied on pre-authorization or verification that pre-authorization was not necessary given to it in then undertaking to perform the services to the patient.

The Court is required at this juncture to accept that averment as true. Whether the Plaintiff can establish it actually relied, or whether, as the Defendants claim, they could not have done so, is a factual issue the Court cannot resolve at the pleading stage.

Put differently, the Court cannot accept at the pleading stage a fact — a counterpoint that the Plaintiffs would have performed the medical services regardless of whether there was or was not a pre-authorization.

The complaint alleges that the Defendants were required by the circumstances, i.e., the pre-authorizations to pay either the billed charges at UCR rates in the event of emergency services in order to avoid balance billing or the UCR rate in the event of non-emergency services.

This averment buttresses the Plaintiff's contention that at the time of the authorization, there was some uncertainty concerning whether the service to be provided, would be considered an emergency service or not.

This averment, if proved, would tend to establish — would also tend to establish the element of reliance, notwithstanding the contention that the Plaintiff would have performed the services anyway.

The Court finds on a motion to dismiss that the Plaintiff has stated viable direct claim under both the, as defined, Emergency Room Mandates Laws and Regulations and the — as defined, prompt pay laws and regulations.

It recognizes that whether there is or is not an implied private right of action for a medical provider under these laws and regulations is a question of law for the Court to determine.

But the Court concludes it should examine and dispositively rule on this issue at a later time with the benefit of a more complete factual record and full briefing of the issue. Such as with a complete — with the benefit of a more complete legislative history.

***13** It determines now that the facts pleaded, if proved, establish factual predicate for a private right of action.

To determine if a statute confers a private right of action, courts consider whether, one, the Plaintiff is a member of the class for whose benefit the statute was enacted.

Two, whether there is any indicia of the legislative intent to create a private cause of action.

And three, an inference that a private remedy exists is consistent with the purpose of the legislative (indiscernible). R.J. Gaydos Agency v. National Consumer Insurance Co., 168 N.J. 255, 272 (2001) requiring coverage for emergency — sorry. The emergency mandate and prompt pay laws contemplate, or in the case of prompt pay laws, explicitly provide for payment to the provider in the case of the mandate, so as to avoid balance billing the patients.

And in the case of prompt pay laws, to compensate with interest for an improper delay in payment.

See N.J.A.C. 11:24A-2.5, N.J.A.C. 11:24-5.8, N.J.A.C. 11:24-5.3, N.J.A.C. 11:24-5.1, N.J.A.C. 11:24-9.1B, N.J.S.A. 17B:26-9.1(d)(9), N.J.S.A. 26:2J-8.1. Generally providing for interest payments to healthcare providers and requiring

coverage for emergency healthcare services and payment of claims in order to avoid balanced billing with patients.

This suggests that providers are among the intended beneficiaries of these laws and regulations and that the legislature, and regulatory authorities intended that providers have a direct means of enforcing these requirements.

One could certainly argue that the primary intended beneficiaries of these requirements are the patients themselves, but that does not necessarily mean that providers are not within the ambit of intended beneficiaries.

The provisions contemplating, or explicitly providing, for payment to providers are an indicator, as noted, of intention to provide a private means for providers to secure such payment.

There is no apparent conflict between governmental enforcement of these laws and regulations and private enforcement.

Indeed, the right of private enforcement would appear to be completely consistent with the intendment of these requirements. Although the movant points to the existence of binding arbitration as a prescribed remedy, thus, in their view, reflecting legislative regulatory selection of an exclusive private remedy, it is not clear on the present record that this is an exclusive remedy.

This is a matter for more complete briefing at a later time.

The Court does not foreclose by this preliminary disposition further consideration of this issue.

The conclusion to await further factual development and briefing is bolstered by the fact that the Plaintiff alleges the Emergency Room Mandate and Prompt Pay Laws are understood by the parties to be incorporated as terms and conditions of their implied contract.

Of course, whether or not this is true is a matter of proof, but the allegation to this effect means that the parties will, in all events, explore in discovery the implications of these laws and regulations in the particular circumstances of this case.

The Court finds that the Plaintiff is not a medical society as contemplated by the Appellate Division in Medical Society of NJ, 376 N.J. Super. 58-59.

***14** According to the pleading in this case, it is an organization that — it is not an organization that represents physicians and physician's interests. Instead, it is a medical practice consisting of physicians, including those who performed the medical services at issue in this case.

The entity is thus the provider for purposes of billing for the services rendered. That circumstance is not what the Appellate Division was referring to in relation to the right (indiscernible) to pursue a private right of action under the laws and regulations discussed therein for payment.

And the medical society court suggested that physicians themselves, such as the Plaintiff in corporate form, could be vested with implied rights of action under these laws and regulations.

The Court agrees with the movant that there is no factual basis pleaded in the complaint by which the Plaintiff could be entitled to an award of attorney fees, even if it prevails on any or all of the causes of action.

The Plaintiff has not pleaded facts establishing an agreed right to attorney fees in the event of successful enforcement of the alleged implied contract.

But differently, it has not alleged that the parties agreed upon a fee shift as a term or condition of the implied contracts that it contends was enforced.

The Plaintiff has also not pointed to any statute or rule of court that would authorize an award of attorney's fees in the circumstances and under the facts pleaded by the Plaintiff.

  

As a result, the Court finds that the facts pleaded do not establish a right to that element of relief and in such respect the pleading is legally insufficient to establish such a right.

The Court is empowered in these circumstances to strike the prayer for attorney's fees just as it would be if it determined there was no factual basis established by a pleading for — for example, punitive damages.

As noted, Printing Mart instructs that when granting a motion to dismiss, the Court should ordinarily do so without prejudice to a right to replead.

Accordingly, the Court concludes that its determination to strike the prayer for attorney's fees as unsupported by the facts and circumstances alleged in the complaint results in the dismissal without prejudice to the claimants right to replead within 20 days of the posting of the Courts disposing of this motion.

Any additional facts to support a claim for an award of attorney's fees or the to seek leave to amend the complaint at a later time to demand such relief.

For the avoidance of doubt, the disposition of this aspect of the Defendant's motion is also without prejudice to any party but including the Plaintiff's right to seek frivolous pleading or discovery sanctions or comparable relief under applicable law as the court rules.

So that will conclude the Court's recitation of its opinions in this matter.

I do thank the parties for their well-presented arguments, both in writing and orally.

I will enter the appropriate order. I am sorry for the long delay in resolving this motion. I am cognizant of the fact that that likely held up the parties in taking their discovery. We will have a prompt case management conference to establish the schedule or partial schedule for moving forward from here.

So thank you for your time. That will conclude our session.

***15** (Proceeding concluded at 5:07 p.m.)

**CERTIFICATION**

I, Christina Gmiterko, the assigned transcriber, do hereby certify the foregoing transcript of the proceedings of the Essex County Superior Court on May 8, 2024, digitally recorded, Time Indexes from 04:01:19 to 05:07:24, and is prepared in full compliance with the current transcript format for judicial proceedings and is a true and accurate transcript of the proceedings as recorded to the best of my knowledge and ability.

<<signature>>

Christina Gmiterko AAERT 052

G & L Transcription of NJ

Pine Brook, NJ 07058

June 21, 2024

**End of Document**

  