2024 WL 3184166 (N.J.Super.L.) (Trial Order)
Superior Court of New Jersey, Law Division,
Civil Part.
Essex County

ESSEX SURGICAL CENTER, LLC, Plaintiff,
v.
UNITED HEALTHCARE SERVICES, INC. d/b/a United Healthcare, Defendants.

No. ESX-L-5387-23.
June 21, 2024.

*1 (Heard via Zoom)
(Date: May 24, 2024

Transcript of Motion Hearing

Matthew Mazzola, Esq., (Robinson & Cole LLP), for the plaintiff.

David Estes, Esq., Eric Katz, Esq., (Mazie Slater Katz & Freeman, LLC), 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., A. Allen, for the defendants.

Honorable Annette Scoca, J.S.C.

TRANSCRIPT ORDERED BY:

SHANNON GREEN, (Thomson Reuters)

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None				

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None

Colloquy

(Portions of audio are indiscernible due to poor CourtSmart recording of attorneys appearing via Zoom.)

THE COURT: This is Essex Surgical Center v. United Healthcare. This is Docket Number ESX-L-5387-23. It is 10:30 a.m. on May 24th, 2024.

I have a motion to dismiss the Plaintiff's complaint filed on behalf of United Healthcare. I have opposition to that motion, and I have a reply to the opposition.

So having said that, I will take your appearances and hear the argument.

MR. MAZZOLA: Sure. Your Honor, this is Matthew Mazzola for the Defendant, United Healthcare Services.

MR. ESTES: Good morning, Your Honor. This is David Estes for Plaintiffs, along with my partner, Eric Katz.

MR. KATZ: Thank you.

THE COURT: Okay. All right. Moving party may proceed.

MR. MAZZOLA: Certainly, Your Honor.

You know, I was going through this — the motions in this — the motions and the (indiscernible) in this case and — you know — they're somewhat lengthy, but — you know — I think this really boils down to one issue here.

If you go to the complaint and you look at the section (indiscernible) of allegations. The first allegation in that section states that all of — or basically the entire complaint is based on an April 25th, 2019, call. And Plaintiff represents in its complaint that during that call United's representative said (indiscernible) verified that Defendant would pay 90 percent of reasonable customary rates for the surgical services that were (indiscernible).

Your Honor, we produced the transcript of this call and it's — it's just a misrepresentation. It's a lie. It didn't happen.

So where do we go from there?

You know, the entire basis of this complaint is false.

There was never an agreement to pay to these surgical services at any rate. Instead, what you had was Plaintiff's representative calling on behalf of a patient asking what the patient's benefit plan said.

Specifically, they asked, hey, what's the reimbursement level under this policy? And they were told 90 percent of reasonable and customary. That was it. There was never, never any agreement to pay the benefits at any (indiscernible). Now, you wonder — well, I'm wondering why this allegation hasn't been withdrawn because there's an obligation under New Jersey law to withdraw allegations that are demonstrably false.

But you have to understand why this allegation was made in this way. And it's because the case law is clear. When you're

talking about the benefits of a (indiscernible) plan and you're just seeking information about a contract, that doesn't create an independent agreement. It can't. Because you're saying, hey, what does this guy's contract say about this? And then that answer is, well, it says this.

***2** Well, that's it. That doesn't create an independent agreement. It's just a response to a question related to a party. It's not something independent.

THE COURT: But counsel, let me just ask you this questions so I make sure I understand because I have read all the papers.

You're saying this outside contract doesn't agree — doesn't exist, so that this really is covered under ERISA (phonetic) but if — if the Court were to find that there was an agreement, then they'd have a common law action for breach of contract or other common law actions, correct? That wouldn't be pre-empted by ERISA, correct?

MR. MAZZOLA: If the Court found that there was an agreement independent of the plan.

So — you know — there's — then yes, that would —

THE COURT: Okay.

MR. MAZZOLA: — be something different.

So basically, there is — there is caselaw where courts have — you know — not dismissed these complaints. I don't think Plaintiff has come up with any cases where the Court actually found that there was an (indiscernible) between the parties, but there's caselaw that these claims weren't dismissed and there's a very distinct difference.

And those types of cases that Plaintiff cites throughout their brief; they're basically situations where there is an agreement to pay a specific rate. And honestly, I'll look at the plastic surgery case in the third circuit and other such cases, but what they're basically saying there is — you know — there was an out of network coverage. So the question wasn't whether — you know — what the plan says about their coverage in place, it's really, hey, will you cover this? And when they said, yeah, we'll cover it and we'll pay it at this — we'll pay for these services at this rate, the Court found, well, that could be — that could —

THE COURT: Right.

MR. MAZZOLA: — stay (indiscernible) —

THE COURT: I understand. I understand your point.

MR. MAZZOLA: Right. So here, it's quite different. And if you look at the conversation — you know — Plaintiff argues that they don't expressly discuss the plan in their complaint.

Well — you know — the Court is allowed to look at documents integral to the complaint or evidence in (indiscernible) complaint here, the entire complaint is based on a phone call.

That phone call, the question posed is what does the policy state? And the answer is, this is what it states. That, quite frankly, is — it relates to the administration of an ERISA plan.

There's no reason for the call, there's no reason for the question if they weren't seeking to learn about what — what is being — what is covered under the plan or how the plan benefits work.

But that's — but that's (indiscernible).

Now — you know — again, I don't understand how this allegation still exists considering that Plaintiff has (indiscernible) it never happened and it should have been withdrawn. So that alone requires dismissal of this complaint.

But then — you know — and what I was getting to before is that the caselaw is kind of clear, right? When you have a benefit verification call — when you're just calling to see, hey, what does this plan pay? That doesn't create an independent agreement.

And that's why Plaintiff is trying to shoehorn this — this call into a promise to pay, which it's just simply not.

***3** And I think the caselaw is very clear on that and that distinction.

And also Plaintiff challenged — tries to challenge that we — you know — the Court should review this transcript, but there's been several cases — in fact, in (indiscernible) New Jersey, as well as in the Superior Court of New Jersey, but the courts haven't reviewed these transcripts because what are we saying here? We're being — we're being told that there's a call, that's the subject matter of the claim. And then when we send the call — you know — then we're being told, no, Judge, don't look at the call. Don't actually look at it. Believe our allegations related to it even though the call clearly refutes what we're saying.

Again, this should have resulted in a withdrawal. And you're stuck with what the facts are. And the facts do not support that this was a — that this was any sort of promise to pay.

And then — you know — when we talk about the state court — state (indiscernible) then the first thing you have to look at is what does this call state? You know? It's basically just a discussion about what someone else's contract says. There's nothing — there's nothing unclear about that.

And then — so how do you have a meeting of the minds? Just look at the transcript. There's no meeting of the minds that they were — that United was trying to bind itself to an independent agreement. There's no discussion of that.

The caller could have said, hey, what would you pay for — if we provided these surgical services, what would you pay?

And then — you know — or does United agree that it would pay this much?

That's not what happened here. It's almost like we're going to ask these vague questions and then try to create some sort of independent promise. When you look at the transcript, which is in front of you, it clearly shows that didn't happen.

And then — you know — there's — the thing about it too, there's really no consideration here. You know? Why — why would we enter into an independent agreement when we already are obligated to pay the Plaintiff's claim for the — I mean, the patient's claim for benefits under an agreement already established?

Furthermore, this is a self-funded plan. So it wouldn't be our obligation to pay the benefits anyway, so why would we agree to bind ourselves to an independent agreement when we're already bound by a separate contract?

And that's all supported by the information that was provided in the call. That's why they don't say, hey, we'll pay this claim for surgical services because they're told that we don't enter independent agreements. You can provide information on the contract in place, but that's it.

Furthermore, the information that was provided had to do with a contract that has nothing to do with the Plaintiff. It's a contract between the (indiscernible). So we're telling the Plaintiff what the plan — what the patient's benefits are. Not what the —

THE COURT: Say that again?

MR. MAZZOLA: — (indiscernible) —

THE COURT: We're telling the what? Say that again.

MR. MAZZOLA: So what I'm trying to say is that when they're asking a question, they're asking on behalf of the patient. Hey, what is this patient's out of network benefits?

***4** They're not directing that conversation to say, hey, what are we entitled to under the Plaintiff's — under the patient's plan? It's really the patient's benefits and that's what they're telling them about. They have no right to do that, and that's why —

THE COURT: Well, wait. Wait. Wait. Unless there's an assignment of benefits. It's a provider calling on behalf of a patient, right?

MR. MAZZOLA: Correct, but they're asking —

THE COURT: When you get authorization —

MR. MAZZOLA: They're saying, hey, we want to — you know — we have this patient in our officer, we just want to know what their plan says, right?

So we're telling them, this is what the — and the Plaintiff — and the patient is entitled to those benefits, not the provider.

That's why the provider is trying to create this independent agreement outside of the claim, but we're just talking about the patient's contract, nothing else.

THE COURT: Yeah, but the provider has to make a phone call to determine — to get pre-authorization or to determine what benefits are available. So are you saying the phone call would have to be between the provider and the patient? I mean —

MR. MAZZOLA: No, and I'm — what I'm saying is the phone calls are permitted. I mean, obviously, the provider can call —

THE COURT: Because a patient — a patient won't even know a medical term or what they're — it's done all the time. I mean, even if you do PIC (phonetic) work — you know — it's always the doctors calling and having the patient sign preauthorization's or assignment of benefits.

So that's why I'm — I understand the contract is between the patient and — but —

MR. MAZZOLA: That's what I was saying. I'm not saying that the —

THE COURT: Yeah, but —

MR. MAZZOLA: — Plaintiff (indiscernible) phone call. Right.

THE COURT: Right. But that — but all the contracts, even in paper, even with Blue Cross or whatever, it's always between the insured and the company, but you're always going to have a third party in there calling to get pre-authorization or whatever.

So you're saying that those situations; there can never be a contract created because the call is made on behalf of the provider?

MR. MAZZOLA: No. No. No.

So this is different than those types of situations because here, what they're alleging is that they were calling to get information as to the benefits, right, when you're talking about the authorization.

My opinion would be, yeah, that wouldn't be necessarily a contract unless the — like Plaintiff tries to allege, unless there was an actual payment or an agreement to pay something, right?

If they say — you know — if you say something, like, oh, your claims shouldn't pay this — which is not even what happened here by the way, but if you promise to pay outside of that agreement, right?

So if you look at the plastic surgery case, what they're saying is there were no out-of-network benefits. And then — and then the Aetna — the company in that case — said, hey, listen we promise to pay you at this rate. We will pay the claim at this rate, right?

That would be — then I could see why that would be a better case to say that's an — that could be a contract, right?

So I'm not saying that it's impossible. There's —

THE COURT: Okay. I just want to make sure. Right. Okay.

MR. MAZZOLA: So what I'm just saying is that in this case, that's not even alleged here.

***5** I mean, it is alleged, but it's just not true and I don't know how you get passed that, right?

And then the other thing is when you look into their opposition, one of the arguments that's stated is, like, listen, we didn't just say it was — it as — you know — a promise to pay, right?

Because I think — there really can be no dispute that that didn't happen. They're saying, well, there also was a course of conduct.

Well, the problem with that is there is no course of conduct alleged.

And New Jersey doesn't — you know — the State of New Jersey doesn't credit conclusory allegations. There has to be something alleged. I don't even know what that's referring to whatsoever. And there's been cases in both the Superior Court of New Jersey and that we've attached to the certification of an attorney from my office in support of our motion, as well as recent cases in the District of New Jersey that's cited in our brief where they said, no, no, no, no; that's not enough. You can't just say course of conduct. You have to explain what is that course of conduct and — you know — these conclusory allegations that — you know — that there was a course of conduct are just insufficient.

So at the end of the day, right, what do we have here?

We have an allegation that my client promised to pay something. That's false. And that's demonstrably false.

And then we — and then the only thing we're relying on here is some unpled course of conduct. That's just insufficient as a matter of law to state claim.

And I think that's what really sums it up. I know there's a lot of briefing, but a lot of that has to do with — you know — cases that are (indiscernible) I feel that if you take a look at the cases they cited, and these specific facts, which — you know — that's one of the things. Like, if you look at that plastic surgery case, I think there's footnote in there where the Court says, like — you know — although in that case, based on those facts, they didn't find that some of the causes of action were granted by ERISA. It's a case-by-case analysis.

And cases like this, where someone is calling up just explicitly asking what is — you know — what are the terms of the plan; how we can say that doesn't — that doesn't relate to an ERISA plan, is just impossible.

And I haven't seen one thing with these type of facts where courts have found differently.

THE COURT: Okay.

At this stage, this is a motion to dismiss. It's not a summary judgment motion.

Okay. Response? Opposition?

MR. ESTES: Good morning, Your Honor.

THE COURT: Good morning.

MR. ESTES: I'll try to be brief. As my colleague has mentioned, we obviously heavily briefed all the issues for you.

THE COURT: Lots of papers.

MR. ESTES: Your Honor, Defendant's motion should be denied because it's like a house — it's like that house on the sand.

It's built on two foundations. One, is extra pleading documents that the Defense has carefully curated to support their position.

And the second basis of this motion is a series of unpublished, foreign cases.

Neither of those foundations is a basis to dismiss forever all claims that my client, a New Jersey provider, has brought asserting New Jersey State law claims.

***6** To drill down a little bit, Your Honor, the first — kind of — foundational issue that's a problem with this case — and Your Honor referenced it in her last question — you know — what type of motion is this?

Is this a motion to dismiss on the face of the pleadings? Or is this a motion for summary judgment?

And I think the answer is clear.

We look at Defendant's reply, which argues the facts. They're trying to construe alleged testimony about the call or — an unauthenticated transcript. They're trying to interpret a letter. We have a lot of factual argument; they're arguing about the admissibility of evidence under a rule — one of the New Jersey Rules of Evidence. A hearsay rule.

This is not the type of argument that you would expect to find under a 462 (sic) motion. And this purports to be a 426 motion. These arguments are premature, Your Honor.

And the materials that they're submitting really paints a picture of what the Defense is attempting to do here, and I would like to just touch upon them very quickly.

For example, this motion to dismiss is built, in significant part, on a summary plan document that the Defendants have submitted to the Court.

The problems with that are multiple. First, you don't have a custodian actually with personal knowledge from United Healthcare saying that that actually is what an attorney purports it to be. Step one.

Step two, this case involves medical services rendered in 2019. They submitted a document to you that's from the year 2017.

Step three, this is — by its own terms — the document, we set aside the initial two defects in Defendant's evidence. The document says it's only a summary and that it's not the controlling document.

So we have a summary, not the actual document.

And then step four, we look at the law.

The Supreme Court of the United States Amera v. Cigna (phonetic), held that this type of document that United Health would

like to present to Your Honor is not the controlling plan document.

So I think that's just one example.

Look at Ms. Farley's (phonetic) certification.

Here, you have a paralegal telling the Court that this action, and the underlying plan, are governed by ERISA.

There's no personal knowledge to make that kind of conclusion.

And what does New Jersey appellate precedent tell us? Well, look at the Finderm (phonetic) decision which is cited in the Plaintiff's brief. It says unequivocally a determination of whether or not a plan is governed by ERISA is a question of fact.

And we can continue to move; we've got the transcript. Here, we have a transcript. There's no chain of custody. An unknown person at United Healthcare went through unknown records, procured an audio recording which they then transferred over to my colleague's paralegal who transcribed it.

There's three or four degrees of hearsay here and they're asking you on this isolated self-serving transcript to rule on summary judgment.

And then the same goes for the letter. In large part, the arguments in the briefing and the reply emphasize the eligibility letter that United purportedly send to my client.

There's no proof whatsoever that that letter was actually sent or when it was received by my client.

Yet, throughout the reply, the Defense falsely states and mischaracterizes the complaint as being based on this phantom letter.

***7** So the first problem with this motion and what it stumbles right out of the gate is it doesn't have anything to do with the actual allegations of the complaint which is the governing standard under 4:6-2(e), Your Honor.

Moving beyond that, subsequently, ERISA does not apply to this case on these facts nor on this procedural record.

The claims that are asserted in this complaint, as Your Honor alluded to, are common law claims under New Jersey related to services provided in New Jersey by New Jersey medical healthcare providers.

And there's a well-established line of cases referred to as the Memorial Hospital Rule beginning several decades ago in the Fifth Circuit.

And that line of decisions was adopted by our appellate courts in St. Peters (phonetic). And more recently, it was also recognized by the Third Circuit in plastic surgery, all of which are extensively briefed.

And most importantly, Your Honor, what I'd like to underscore is that — for example — the complex business litigation judge in Essex County, Judge Lynott and many other leading juris across New Jersey Superior Courts have entered decisions on this precise issue, and they all have unanimously held that there's no ERISA pre-emption on the face of the pleadings under these factual circumstances.

And those holdings were highlighted in Exhibit A to my certification, Your Honor.

The big picture here, and the question that I'd like to highlight, Your Honor, is what the Defense — what the insurance company is trying to do here is create a type of legal structure where there's no remedy and there's no forum.

Under these circumstances, my client has no ability to sue in federal court and has no right to sue under this plan document that the Defense keeps referring to and retreating to.

The only rights are those rights that they have as New Jersey citizens for their direct dealings relationship with Defendant, United Healthcare.

And what the Defense is trying to do is to create a situation where the patient is left financially responsible and bearing the medical debt that arises from the false and misleading statement by a United Healthcare employee. And that's wrong, Your Honor.

And then just quickly a third point I'd like to make is Defense keeps referring to — you know — federal decisions.

We all know, we've all litigated for a long time, that in federal court the pleading standard is much different. It's the standard based on Twamly (phonetic) and (indiscernible).

And no doubt, if a complaint — if this complaint had been filed in federal court, it would be subject to a more rigorous examination under those standards.

But we're not in federal court. It wasn't filed there. It's Plaintiff's prerogative to file their complaint where they please. They filed it in state court. It's subject to the Printing Mart standard, which requires a generous and hospitable review for all the allegations.

And I think when we apply the correct standard to the facts in this case, it's clear that each of the five counts was adequately pled. It provides the Defendants the notice that they're — that is required under our court rules. And I would just like to highlight an example of that.

There's a lot of discussion during my colleagues' argument about whether the complaint adequately pleads the applied contract claim; the first count. But I think that argument highlights exactly what the problem with United Healthcare's motion — which is that they're trying to blur the facts and the law.

***8** The allegation here is not that there's an express contract, a written agreement between my clients and United Healthcare.

So of course there's no express meeting of the minds that's written out — you know — in an extensive, detailed contract that covers all the different aspects of contract —

This is an implied contract. And our caselaw in New Jersey, including for example, the Supreme Court's decision Troy v. Rutgers (phonetic), makes it very clear that when you're asserting an implied contract, it's based on both the parties' conduct and the circumstances.

If you look at Whicker (phonetic), you — it can even be based on silence. And here, what's alleged is the parties have, of course, a dealing that provides the context to that — the statements that occurred during the telephone call.

And both of those prongs, both the course of dealings, the context of the industry custom in this area, as well as the statements during those calls all together comprise the factual basis for Plaintiff's claims in this action, Your Honor.

And let me check my notes if there's anything else to emphasize.

I think just two more quick points, Your Honor —

THE COURT: Go ahead.

MR. ESTES: — and then I'll wrap up.

THE COURT: Go ahead.

MR. ESTES: A large part of my colleague's argument here — the opening argument — involved characterizing the

transcript. What did it mean? What was the purpose? It was — characterized as a call to verify or check benefits.

It doesn't say that in the transcript. And what's happening here is you have a counsel trying to act like a witness and testify and interpret the mind of my client, of his client. I think this is very clearly argument for summary judgment, Your Honor.

Unless you have any other questions, I'll leave it there.

THE COURT: Counsel, I'd like to give Mr. Mazzola a chance to respond.

MR. MAZZOLA: Sure, Your Honor. There's a couple of things I want to touch on.

First, when you go back to the phone call and transcript, Plaintiff's counsel says that it's unauthenticated. It's clearly authenticated, and they don't offer any — anything to show that the transcript is false.

In fact, quite frankly, they have an obligation to withdraw allegations that are false.

Now, I don't understand the (indiscernible)

interpreting what is in the call that was had. You can look at the transcript yourself.

The fact remains that this entire complaint is based on one allegation that United — and this is a quote. A United representative Sid (phonetic) verified that Defendant would pay 90 percent of reasonable and customary rates for the surgical services.

That statement is false. We cannot go on from there. It is not for summary judgment.

First of all, when Plaintiff says that he's failing to realize that — or failing to acknowledge that documents referenced in a complaint or evidence referenced in the complaint, including phone calls, can be reviewed by the Court because it's integral to the complaint.

Here, this is it. This is the — this is the thing referenced in the complaint. The phone call.

So where — so what are we really doing? What are we saying here? They're saying, well, we can allege whatever we want and although we can prove that it's not true right now, why would we have to wait for summary judgment? It's integral to the complaint. The Court is fully entitled to review it.

***9** When you talk about the course of conduct allegation, yes, federal pleading requirements are more stringent and more difficult. But New Jersey still has pleading requirements. And one of those requirements is that you cannot get past a motion to dismiss by just asserting a conclusory allegation.

Here, stating that, oh yeah, the parties' course of conduct.

Well, what is the course of conduct? Here, we have one situation where there's a call where we already proved that we didn't promise to pay anything. We submitted a letter — an authorization letter to Your Honor because they keep calling the claims pre-authorized. That's the only document that would show it's a (indiscernible). That letter says that there's no guarantee of payment, right?

So — so — you know — it's hard to see; where is there a course of conduct here where we guaranteed to Plaintiff at their billed charges? Which is, essentially, what they're alleging.

Some other things that I — I have to respond to. When Plaintiff is saying that his client has no way to sue United. Well — you know — that doesn't mean that we can make up causes of action or we can create claims where none exist.

It's — it's really not true that — first of all, United doesn't have a contract with the Plaintiff.

His burden is to show that there is a contract, right? They have not been able to do so, so what are they saying? They're pleading to the Court, well, what else are we supposed to do?

Well, that's not really our problem because United doesn't have an agreement with the Plaintiff. It has an agreement with the patient. And that is the plan.

Now, when you're talking about the plan document here, we have authenticated that as well from a witness with knowledge. I'm not sure what Plaintiff's counsel is talking about. It's clearly authenticated by a certification for the Court. And Plaintiff is challenging whether this is — you know — the governing plan document.

The point is, is that this document is, in this certification, stated to be the governing plan document and it indicates that the plan itself is governed by ERISA.

And that's really what we're trying to show here.

But I think more importantly, even if the Court says, okay, we can't consider the SPD — the Summary Plan Description — which it should — which it should not do.

Let's look at the — the statement for claims. Again — you know — I'm not sure where we go here.

We have an authenticated transcript of the phone call referenced in the complaint that clearly says nothing of what Plaintiff alleges it does.

And Plaintiff hasn't acknowledged that, yes, its allegations in Paragraph 6 are false.

So I'm not interpreting anything. I'm giving you the transcript. I'm giving you the allegation. They don't match up. And the caselaw supports our position that when you're talking about a call like this, a benefits verification call, when the information requested only has to do with — you know — what is the reimbursement level of this plan and it's not a promise to pay, then that's it. It's clear.

And the cases that Plaintiff is citing — I'm talking about (indiscernible) — all of those cases are different because those cases, you're talking about oral conversations that were not transcribed. Right?

So it's, like, an oral — there was a call between the parties, there's not specific dates, we weren't able to get the transcript, things like that.

***10** But when it is transcribed — you can go look at the cases we cited. The Court's considered the transcript, they review it, and they say, well, there's no promise here. There was no promise to pay. You can't interpret this as an agreement independent of an ERISA plan when it's just asking questions about the ERISA plan.

So that's it. And — you know — going forward, if the Court — you know — if this case was to go forward — I'm not really sure how it goes forward considering that the one allegation here is demonstrably false. And it's not a — like I said, it's not a summary judgment issue because it's the — it's referenced in the complaint.

So — you know — the only way that I see — you know — the only thing that can happen here is that this complaint should be dismissed in its entirety because it was based on a demonstrably false allegation.

If Your Honor has any further questions, I —

THE COURT: Okay. I want you to address the representation that the allegations are false, counsel. Demonstrably false.

MR. ESTES: I'm sorry, Your Honor. You broke up for a moment.

THE COURT: I'm sorry.

MR. ESTES: Was that addressed to me?

THE COURT: Yes, I want you to address — respond to Mr. Mazzola's allegations that the allegations in the complaint are false.

MR. ESTES: Well, I —

THE COURT: Demonstrably false.

MR. ESTES: Demonstrably false. I don't think that's true at all.

I think if you look at Paragraph 6 and 7 of the complaint, it states that my client contacted United Healthcare and they — they, among other things during that call, they inquired what the reimbursement rate would be for the subject services.

I think it's undisputed — even if setting aside that — Plaintiff's objections to the transcript — you know — for the sake of argument, if the Court were to consider it on the face of the pleadings, it actually supports our position because it states unequivocally that United represented they were going to pay 90 percent of the market rate, which is referred to by a term of a art in this area which is that reasonable and customary rate, sometimes referred to by the acronym UCR —

And because — on that representation, they induced Essex Surgical to move forward and render the services.

Ultimately, it was a bait and switch.

United didn't pay that amount, they paid a much lower amount. There's about — as set forth in the complaint, there's a dispute — there's an outstanding in amount that's in dispute of approximately $54,000.

That's what this case is about. It's about the words, it's about the deeds of United Healthcare.

It's not about the plan — the plan document that runs between United and the patient.

And they're trying to use that as a shield so that they can't be held accountable for what they said and what they did, but that's not what ERISA is for, Your Honor.

And I'd also point out another problem with the approach that the Defense is proposing that the Court take.

There's a lot of implied factual conclusions in Defense counsel's interpretation of that transcript.

For example, there's a characterization that my client called with the intent to determine the content of the plan.

That's not supported in the transcript.

That's one person drawing an inference as to what the parties' intent was.

What actually happened, when I read it — and I'll just — just for context, Your Honor, I represent a lot of providers in state and federal court in reimbursement disputes in New Jersey and across the country. And what happens with these —

***11** THE COURT: Let's —

MR. ESTES: — type of calls —

THE COURT: — read it on the record.

MR. ESTES: — is that they don't have —

THE COURT: Let's read the transcript on the record.

MR. ESTES: I'm sorry?

THE COURT: Let's read the transcript on the record.

MR. ESTES: Okay.

THE COURT: What exhibit is it?

MR. ESTES: It is — it's part of Teresa Lozano's (phonetic) certification, Your Honor. And it's Exhibit A to her certification.

THE COURT: Okay. Hang on.

MR. ESTES: And while — while you're pulling it up, Your Honor, I'll just address a point earlier. There was a point that this was a certified transcription. And that there's no authority for our objection as to its authentication.

Plaintiff was referring to Court Rule 1:34-5, which requires any transcript that a court would credit to have been prepared and certified by a certified court reporter subject to the rules of New Jersey, as opposed to Defense counsel's paralegal.

Once Your Honor has the transcript, we can move forward.

THE COURT: Yeah, I'm trying to find the certification.

MR. ESTES: Yeah, I know it's —

THE COURT: We have the certification that Cathryn Katchen (phonetic) —

MR. ESTES: That's the document identifying (indiscernible) defense counsel, so it's going to be past that.

THE COURT: Okay. We have a stipulation —

Because I read this online and I'm looking at the papers.

MR. ESTES: Uh-huh.

THE COURT: Okay. We have a transcript of decision. Okay. That's Exhibit C.

MR. ESTES: I'm sorry, go —

THE COURT: Wait. Whose decision is this? Wait.

Oh, no. That's another judge. Honorable Bruno Mongiardo. That's an Appellate Division —

Let me see.

These are other judge's decisions.

Exhibit A is the audio file, right?

MR. MAZZOLA: Yes.

THE COURT: Okay. Let's go.

MR. MAZZOLA: On the second to last page is where the reimbursement (indiscernible) is discussed.

THE COURT: Okay.

MR. ESTES: Your Honor, did you want to read the entire —

THE COURT: Well, yeah. Let's read it. Yeah, let's read the transcript.

MR. ESTES: Okay. Okay.

> "SPEAKER 1: Thank you for calling United Healthcare. My name is Sid, your resolution specialist. May I have your name? SPEAKER 2: Hi, Sid. My name is Evalisa (phonetic). That's Evalisa, last initial, C as in Charles.
>
> SPEAKER 1: Thank you so much, Evalisa. How are you doing today?
>
> SPEAKER 2: I'm doing good.
>
> SPEAKER 1: All right. So please give me one quick moment while I document my last call.
>
> I'm sorry about that. Yes.
>
> Now, thank you so much, Evalisa, for your patience.
>
> And let's see —
>
> You're calling from the office of Essex Surgical, right?
>
> SPEAKER 2: Correct. Essex Surgical.
>
> SPEAKER 1: Thank you. And this is for patient M.G.?
>
> SPEAKER 2: Correct.
>
> SPEAKER 1: Thank you.
>
> SPEAKER 2: And I am calling to obtain out-of-network benefits for an ASC. I need to verify her benefits, and if a procedure requires prior authorization.
>
> SPEAKER 1: Sure thing. And let's see —
>
> Yes. Are you in network with United Healthcare?
>
> SPEAKER 2: No, we're out of network, sir.
>
> SPEAKER 1: Thank you so much. And may I have the procedure code?
>
> SPEAKER 2: The first procedure code is 63075 and then 63076.
>
> ***12** SPEAKER 1: Okay.
>
> SPEAKER 2: 22856. SPEAKER 1: All right. SPEAKER 2: 22858 and 7600 with a TC modifier.

SPEAKER 1: TC modifier — I'm sorry, I didn't — I didn't understand that. SPEAKER 2: TC modifier component because I'm a facility, so those are the CPT codes. Those are the CPT codes that the doctor sent over to us. I'm just curious to know if one pre-cert is required so I can advise the physician and then I need to obtain out of network benefits. SPEAKER 1: — "

So it is a pre-cert issue too. Speaker —MR. ESTES: That's part of it. THE COURT: Right.

MR. ESTES: And the first part is the pre-cert and then it transitions to other issues.
THE COURT: Right.

"SPEAKER 1: Thank you so much. Let's see. Well, for Code 228 UH 56 medical notes may be requested during the processing of the claims. For the Code 2858, also for medical notes requested. And then let's see —

For the Code 63075 — and let's see — and also for 63076, medical notes are requested. SPEAKER 2: So then it's in the best interest of the provider to submit medical documentation for pre-determination prior to procedures?

SPEAKER 1: Uh, yes. And let's see — 76000 — yes. This is the valid available code as well.

Let me check if they require a prior authorization or not. 6375 and 6306 are spine surgery, right?

SPEAKER 2: Correct.

SPEAKER 1 — being United Healthcare: And the Code 22856 and 22858 is also spine surgery.

All right. Let's see for our network if they require authorization or not.

SPEAKER 2: Yes. The doctor and the facility are out of network. I need to know if it needs prior authorization.

SPEAKER 1: Let me see. So please give me a moment. I need to check that one, if the prior authorization is required or not.

SPEAKER 2: Okay.

SPEAKER 1: Thank you so much for your patience for the codes, which you've given me. If the codes are billed for non-scheduled services only — only then a prior authorization is required.

SPEAKER 2: I'm not following. Either it should be — it should be scheduled — I'm a surgical center. These are — it's elective, it's not emergent. My question is, is prior authorization required?

SPEAKER 1: Well, if it's scheduled then it's not required. If it is scheduled, then it's not required.

SPEAKER 2: If it's scheduled, it's not required. And then it's not scheduled, it is required?

SPEAKER 1: Yes. Well, this is actually due to our recent updates in our policies. That's right.

SPEAKER 2: Okay. Not required pre-cert — pre-determination. Yes, for medical necessity.

Okay. All right. So for this patient, when was the effective date of the police? SPEAKER 1: Let's see — for this patient, effective — most recent effective date is 1/1 of 2018.

SPEAKER 2: Okay.

SPEAKER 1: An original effective date is 1/1 of 1999."

MR. MAZZOLA: Your Honor, could I interrupt you?

THE COURT: Go ahead.

MR. MAZZOLA: So I would submit to your original question and the point that I was making that in one call, different subject matter is covered.

So I think what we've read — you know — from past the introduction up to this point is that the prior authorization or prior certification part of the call, and if you look at the proposed plan document that the Defendants have cited, it defines that it's a process to address what's called medical necessity.

***13** THE COURT: All right.

MR. MAZZOLA: Which is whether or not the treatments are necessary. And I think going forward now, it shift to a different topic —

THE COURT: Right, but my point is it wasn't just —

And you didn't let me finish.

MR. MAZZOLA: I'm sorry.

THE COURT: My point is there — I was just talking about the interpretation of the call.

MR. MAZZOLA: Uh-huh.

THE COURT: It was more than just how much are you going to pay.

MR. MAZZOLA: Yes.

THE COURT: There was — there were a lot of things, okay?

So let me finish.

MR. MAZZOLA: Agreed.

THE COURT: Okay.

So then it goes —

Okay.

"SPEAKER 1: An original effective date is 1/1 of 1999.

SPEAKER 2: Okay. And if there is an out of network deductible —

SPEAKER 1: Yes, there is.

SPEAKER 2: How much?

SPEAKER 1: Let's see. It's 1,200. The whole amount has been met.

SPEAKER 2: Okay. And what's the coverage of the plan?

SPEAKER 1: It's 65 percent of eligible expenses after the deductible.

SPEAKER 2: So it's covered at 65 percent?

SPEAKER 1: Yes.

SPEAKER 2: Okay. Is this a self-funded or fully funded plan?

SPEAKER 1: Okay. Let me check. It's a self-funded plan.

SPEAKER 2: And there is an out of pocket max?

SPEAKER 1: Yes, there is.

SPEAKER 2: How much?

SPEAKER 1: Let's see. It's 5,000. And met amount is 4,220.15.

SPEAKER 2: I'm sorry, 4,220.15 have been met already?

SPEAKER 1: Yes.

SPEAKER 2: So their out of pocket max has almost been met and after that has been met it is still covered at 65 percent?

SPEAKER 1: No. It will be covered at 100 percent.

SPEAKER 2: At 100 percent coverage?

SPEAKER 1: Yes.

SPEAKER 2: Okay. And let — and what is the reimbursement level on this policy?

SPEAKER 1: Let me check. It is 90 percent of reasonable and customary.

SPEAKER 2: So it's 90 percent of reasonable and customary, RNC?

SPEAKER 1: Yes.

SPEAKER 2: Okay. And does this run on calendar or contract year?

SPEAKER 1: This will be calendar year.

SPEAKER 2: Calendar year? Okay. And Sid, can I just get a reference for today?

SPEAKER 1: Please. Sure thing. The reference number — "

THE COURT: And he gives them a reference number and it goes on.

So there's a lot there.

MR. ESTES: Yeah.

MR. MAZZOLA: Your Honor —

MR. ESTES: (Indiscernible) —

MR. MAZZOLA: There is a lot. There's a lot, but none of it is saying —

You have to realize, when you ask for somebody — whether it needs to be pre-certified — that's the first half of the call. And they're saying, no. They're saying, no, it doesn't need to be pre-certified.

THE COURT: Because it's already scheduled, which I don't understand that.

MR. MAZZOLA: I think that (indiscernible) is talking about payment under the policy, right?

Plaintiff is alleging in the complaint that — and you asked him to address this, and he didn't, respectfully. That we promised to pay the claim to the services at issue —

THE COURT: It will be covered at 100 percent. It will be covered at 100 percent.

MR. MAZZOLA: But Your Honor, the difference here —

What are we talking about, Your Honor?

THE COURT: All right.

MR. MAZZOLA: We're talking about whether it's covered. There's no dispute that this was covered. We're talking about the reimbursement — a promise to pay at a specific rate. That is not agreed here.

***14** THE COURT: It's 90 percent of what's reasonable —

What is the reimbursement level on the policy? 90 percent of reasonable and customary.

MR. MAZZOLA: Right, but Your Honor he didn't — we didn't say we'll pay your claim for these services. The problem here is that the claim wasn't submitted. It's — that the complaint alleges something that is not in there.

If you ask you what is — and other courts have found this specific question when you're asking, what is the reimbursement level of this policy, just like when you're asking — you know — about what is the out of network benefits, you know? And for out of network services, what would be covered? Coverage is different than what's paid. You have to look at the plan. For example, saying that 90 percent of reasonable and customary is what the policy says isn't, hey, for these specific surgeries — services — we're going to pay you 90 —

THE COURT: I understand that.

MR. MAZZOLA: — percent of —

THE COURT: But isn't that —

MR. MAZZOLA: — (indiscernible) and that's what they're saying.

THE COURT: Isn't —

MR. ESTES: Your Honor —

Your Honor, I'm sorry, you're muted.

THE COURT: I'm muted?

I'm sorry. All right. I hear everybody's arguments. And we have a difference of interpretation here.

MR. ESTES: Your Honor, can I just make one brief point —

THE COURT: Yes.

MR. ESTES: — if you'll indulge me?

I think that this argument in our exercising reading the transcript, trying to interpret it in a highly complicated — in a — you know — a niche, an industry niche where this has meaning kind of underscores the point that I'm trying to make, which is that these are fact issues. We need depositions. We need to talk to the people that were on the call. We need to talk to people that practice and do business in this area. And these issues are appropriate for summary judgment.

Thank you.

MR. MAZZOLA: All right. Can I just respond to that?

THE COURT: I — okay —

MR. MAZZOLA: This has (indiscernible) —

THE COURT: — listen. I have had — we have spent — I've read all your papers, we've spent almost 45 minutes of oral argument. And I think it's clear just based upon the descent on this call that this is not ripe for dismissal at this point.

You may be right at a later date when some discovery is taken, but at this point the law — 462(e) allows a defendant to file a motion in lieu of an answer where Plaintiff's complaint fails to state a claim upon which relief could be granted.

I am bound by the Mart Morristown v. Sharp Electric Corp. standard, 116 N.J. 739, 746 (1989).

"A reviewing court searches the complaint in depth and with liberality to ascertain whether the fundament of a cause of action may be gleaned even from an obscure statement of claim, opportunity be given to amend, if necessary.

The Court will only consider the documents referenced in the complaint. The documents referred to in the complaint will be considered and will not convert this motion into one for summary judgment."

In Plastic Surgery Center v. Aetna, 967 F.3d 218, Third Circuit (2020), the Third Circuit reversed the District Court's granting of a motion to dismiss claims of breach of contract and promissory estoppel because the plan administrator was alleged to have agreed to made payments to the provider which amounted to an oral agreement.

***15** In Plastic Surgery, Aetna specifically agreed to a negotiated rate of payment, Id. at 224. The Court determined that Plaintiff's breach of contract and promissory estoppel claims were not pre-empted by ERISA because they did not relate to ERISA plans as the claims did not require reference to ERISA plans since there were not claims for benefits under an ERISA plan and not otherwise premised on ERISA plans.

The Court rules these claims did not have a connection with ERISA, as they did not arise out of a relationship ERISA intended to govern, and allowing these claims did not impermissibly interfere with ERISA plan administration.

The provider was out of network and concerned about how it would be compensated. So before getting — agreeing to

provide care, a contact that — to confirm that it would make payment. Pursuant to an alleged oral agreement with the Center and Aetna, entered in each case, the Center provided the specified services in exchange for payment of a reasonable amount and at the highest in-network level under the plan. Once the Center performed the procedures, Aetna allegedly refused to live up to its end of the bargain.

Here, Plaintiff claims a healthcare reimbursement dispute arising out of the statement Defendant made to Plaintiff in their course of prior dealings regarding reimbursement for a spinal surgery performed in May of '19.

Plaintiff argues Defendant indicated reimbursement at 90 percent of the market rate, induced Plaintiff to render surgical services but that after Plaintiff performed its end of the bargain, Defendant issued a payment significantly less than the reasonable and customary amount for critical services.

Here, their question is whether there's an oral agreement that created an independent cause of action. The mere fact that a claim arises against the factual backdrop of an ERISA plan does not mean it makes reference to that plan.

For ERISA pre-emption, courts focus primarily on whether claims directly effect the relationship among the traditional ERISA entities, the employer, the plan, and its fiduciaries, and the participants and beneficiaries and interfere with plan administration or undercut ERISA's stated purpose.

Plaintiff claims this is a healthcare reimbursement dispute arising out of the statements Defendant made to Plaintiff in their course of prior dealings regarding reimbursement for spinal surgery performed in May of 2019.

Plaintiff argues Defendant indicated reimbursement at 90 percent of the market rate, induced Plaintiff to pay — to render surgical services, but after Plaintiff performed its end of the bargain, Defendant issued a payment significantly less than the reasonable and customary amount for Plaintiff's critical services.

Plaintiff argues federal pre-emption is a fact-sensitive, affirmative defense that cannot be resolved on the face of the complaint.

The Court agrees. This matter is before the Court on a motion to dismiss for failure to state a claim. The Court must allow Plaintiff's claims to proceed if it accepts all factual allegations in the complaint as true and draws all reasonable inferences in the Plaintiff's favor.

Plaintiff alleges it is an oral agreement between the parties.

The protection of plan participants and beneficiaries is not advanced by extending an expressed pre-emption to out of network providers and limiting their universe of remedies to those outlined in Section 502(a).

***16** That's Plastic Surgery Center P.A., 967 F.3d at 238. And healthcare providers are generally not considered beneficiaries or participants under ERISA.

After review of each count of the complaint, the Court finds Plaintiff has stated a claim that is plausible on its face. And at this juncture, the Court cannot determine whether Plaintiff's claims are or are not pre-empted.

Do some discovery and you may be successful counsel on a motion for summary judgment. I just do not believe that at this point I can, in all good faith, dismiss the complaint. Thank you.

(Proceeding concluded at 11:19 a.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 24, 2024, digitally recorded, Time Indexes from 10:29:56 to 11:19:19, 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