UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

ADVANCED SURGERY CENTER, Plaintiff, -against- UNITED HEALTHCARE INSURANCE COMPANY, Defendant.	Index No.: **COMPLAINT**

Plaintiff, Advanced Surgery Center ("Plaintiff"), on assignment of Elizabeth O., by and through its attorneys, Halkovich Law, LLC, by way of Complaint against United Healthcare Insurance Company ("Defendant"), alleges as follows:

PARTIES, JURISDICTION, AND VENUE

1. Plaintiff is an Ambulatory Surgical Center registered to do business in the State of New Jersey with its principal place of business located at 1608 Lemoine Ave, Suite 101 Fort Lee, NJ 07024.

2. Upon information and belief, Defendant is engaged in providing and/or administering health care plans and/or policies in the State of New Jersey.

3. Jurisdiction is proper in this Court pursuant to 28 U.S.C. § 1331 and 29 U.S.C. § 1132(e). The insurance policy at issue is governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq*. The administrative remedies have been exhausted.

FACTUAL BACKGROUND

4. This dispute arises from Defendant's failure to properly reimburse Plaintiff for the medically necessary, out-of-network, reasonable, and valuable facility services provided to Patient on August 1, 2019.

5. Specifically, on August 1, 2019, Patient underwent surgical treatment for which Plaintiff provided facility services. (*See*, **Exhibit A**, attached hereto.)

6. At the time of her treatment, Patient was the insured and/or beneficiary of an employer-based health insurance plan for which Defendant served as claims administrator.

7. Patient assigned her applicable health insurance rights and benefits to Plaintiff. (*See*, **Exhibit B**, attached hereto.)

8. Prior to her treatment, Patient sought and received prior authorization for the treatment in question, including for Current Procedural Terminology ("CPT") codes 49585, 49560, 49568, 15734, 13101, 13102, and 11981. (*See*, **Exhibit C**, attached hereto.)

9. Specifically, Defendant's prior authorization specified the above-referenced CPT codes, stating in reference to them, "it was determined the following service is eligible for Outpatient Facility coverage." *Id*.

10. After treating Patient, Plaintiff submitted a UB04 medical bill to Defendant seeking payment in the amount of $117,652.00, in accordance with Plaintiff's usual and customary rates. (*See*, **Exhibit D**, attached hereto.)

11. As an out-of-network facility, Plaintiff does not have a network contract with Defendant that would determine or limit payment for services rendered to Defendant's members.

12. In response to Plaintiff's medical bill, on August 26, 2019, Defendant "allowed" reimbursement in the total amount of $12,478.66 for CPT 49585 *only*, of which $5,794.90 was

paid by Defendant, and $6,689.76 was applied towards Patient's coinsurance and deductible liability. **(***See***, Exhibit E**, attached hereto**.)**

13. Despite the prior authorization, CPT codes 49560, 49568, 15734x2, 11981, and 13101 were denied by Defendant, and were appended with "Remark Note" designation "CY."

14. "Remark Note" designation "CY" was defined within Defendant's explanation of benefits ("EOB") form as follows:

> This payment has been reduced by the amount that is above the eligible expense amount for out-of-network services under your plan in your area. If you are billed for an amount above the eligible amount, please call Viant directly at 1-800-598-6888.

Id.

15. However, regardless of Defendant's pricing of the subject services, Defendant failed to issue reimbursement for all but one of the performed CPT codes, even though each code was previously authorized.

16. Plaintiff submitted multiple internal appeals to Defendant challenging Defendant's denials as improper under the terms of Patient's insurance plan, and inconsistent with the prior authorization obtained by Patient.

17. However, Defendant failed to issue any additional reimbursement in response to Plaintiff's appeals.

18. Upon information and belief, Defendant has failed to issue proper reimbursement for Patient's treatment in accordance with the terms of her insurance plan.

19. As a result, Plaintiff, has been damaged in the total amount of $105,173.34.

20. Accordingly, Plaintiff brings this action for recovery of the outstanding balance.

COUNT ONE

FAILURE TO MAKE PAYMENTS PURSUANT TO MEMBER'S PLAN UNDER 29 U.S.C. § 1132(a)(1)(B)

21. Plaintiff repeats and realleges the allegations set forth in paragraphs 1 through 20 of the Complaint as though fully set forth herein.

22. Plaintiff avers this Count to the extent ERISA governs this dispute.

23. Section 502(a)(1), codified at 29 U.S.C. § 1132(a) provides a cause of action for a beneficiary or participant seeking payment under a benefits plan.

24. Plaintiff has standing to seek such relief based on the assignments of benefits obtained by Plaintiff from Patient.

25. Upon information and belief, Defendant acted in a fiduciary capacity in administering any claims determined to be governed by ERISA.

26. Plaintiff is entitled to recover benefits due to Patient under any applicable ERISA plan or policy.

27. As a result, Plaintiff has been damaged and continues to suffer damages in the operation of its medical practice.

COUNT TWO

BREACH OF FIDUCIARY DUTY AND CO-FIDUCIARY DUTY UNDER 29 U.S.C. § 1132(a)(3), 29 U.S.C. § 1104(a)(1) and 29 U.S.C. § 1105 (a)

28. Plaintiff repeats and realleges the allegations set forth in paragraphs 1 through 27 of the Complaint as though fully set forth herein.

29. 29 U.S.C. § 1132(a)(3)(B) provides a cause of action by a participant, beneficiary, or fiduciary to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

30. Plaintiff seeks redress for Defendant's breach of fiduciary duty and/or Defendant's breach of co-fiduciary duty under 29 U.S.C. § 1132(a)(3), 29 U.S.C. § 1104(a)(1) and 29 U.S.C. § 1105 (a).

31. 29 U.S.C. § 1104(a)(1) imposes a "prudent man standard of care" on fiduciaries.

32. Specifically, a fiduciary shall discharge its duties with respect to a plan solely in the interest of the participants and beneficiaries and (A) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan; (B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; (C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and (D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter. 29 U.S.C. § 1104(a)(1).

33. 29 U.S.C. § 1105(a) imposes liability for breaches of co-fiduciaries.

34. Specifically, a fiduciary with respect to a plan shall be liable for a breach of fiduciary responsibility of another fiduciary with respect to the same plan in the following circumstances: (1) if he participates knowingly in, or knowingly undertakes to conceal, an act or omission of such other fiduciary, knowing such act or omission is a breach; (2) if, by his failure to comply with section 1104(a)(1) ["prudent man standard of care] of this title in the administration of his specific responsibilities which give rise to his status as a fiduciary, he has enabled such other fiduciary to commit a breach; or (3) if he has knowledge of a breach by such

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