6-14-2012

Order on Motion to Dismiss and for Summary Judgment (Coliseum Medical Center)

Alice D. Bonner
Superior Court Judge

IN THE SUPERIOR COURT OF FULTON COUNTY
STATE OF GEORGIA

COLISEUM MEDICAL CENTER, LLC, d/b/a COLISEUM MEDICAL CENTERS; EASTSIDE MEDICAL CENTER, LLC, d/b/a EMORY EASTSIDE MEDICAL CENTER; CARTERSVILLE MEDICAL CENTER, LLC, d/b/a CARTERSVILLE MEDICAL CENTER; REDMOND PARK HOSPITAL, LLC, d/b/a REDMOND REGIONAL MEDICAL CENTER; PALMYRA PARK HOSPITAL, LLC, d/b/a PALMYRA MEDICAL CENTERS; FAIRVIEW PARK, LIMITED PARTNERSHIP d/b/a FAIRVIEW PARK HOSPITAL, and DOCTORS HOSPITAL OF AUGUSTA, LLC, d/b/a DOCTORS HOSPITAL (AUGUSTA) Plaintiffs,	
v.	Civil Action File No. 2011CV198928
AETNA WORKERS' COMP ACCESS, LLC; MEDICOR MANAGED CARE, LLC; TRAVELERS INDEMNITY COMPANY; LIBERTY MUTUAL INSURANCE COMPANY; BUILDERS INSURANCE (A MUTUAL CAPTIVE COMPANY); SEDGWICK CLAIMS MANAGEMENT SERVICES, INC.; HARTFORD INSURANCE COMPANY OF THE SOUTHEAST, and SENTRY INSURANCE, A MUTUAL COMPANY. Defendants.	

ORDER ON MOTIONS TO DISMISS AND MOTION FOR SUMMARY JUDGMENT

On May 7, 2012, counsel appeared before the Court to present oral argument on Defendant Builders Insurance's ("Builders") Motion to Dismiss, Defendant Aetna Workers' Comp Access, LLC's ("Aetna") Motion to Dismiss Plaintiff's Original Complaint for Lack of Subject Matter Jurisdiction and for Summary Judgment, and Defendant

Aetna's Motion to Compel Production of Documents and for Sanctions. Upon consideration of the arguments of counsel, the briefs submitted on the motions and the record of the case, this Court finds as follows.

Plaintiffs are Georgia hospitals that claim they were underpaid on bills for prosthetics, implants and high cost drugs they provided to patients entitled to benefits under the Georgia Workers' Compensation Act (the "Act"). In 2006, Plaintiffs entered into a Letter of Agreement ("LOA") with Aetna that set forth, among other things, a specific payment schedule for services the Plaintiffs provided to members of Aetna workers' compensation access network ("Network"). The Network was designed to connect various payors, or claims administrators who administer workers' compensation coverage, with service providers, like Plaintiffs, who agree to offer medical services, sometimes for a discount, for Network members. In exchange, Aetna agreed to designate Plaintiffs as preferred providers for patients eligible for workers' compensation benefits. In addition to negotiating rates with hospitals and establishing a network of payors, Aetna served as the administrator of the Network and processed claims pursuant to the rate schedule set forth in the LOA. Aetna is not responsible for payment under the LOA.

Under the LOA, Plaintiffs agreed to provide certain "general" services at a 2% discount from the rate established under the Act. However, Plaintiffs were entitled to 80% of their billed charges for certain special services, such as prosthetics, implants and high cost drugs greater than $500.

Plaintiffs contend that Aetna failed to process claims for "special" services at the rates established under the LOA and, in turn, that Defendant Payors failed to pay claims under the LOA's contracted rate for the identified "special" services. Plaintiffs have asserted a claim against Aetna for Breach of the LOA and a claim against Defendant Payors as third party beneficiaries of any contracts between Aetna and Defendant Payors that obligated Defendant Payors to pay for hospital services under the rates set forth in the LOA. Both Builders and Aetna have filed motions to dismiss, and Aetna also filed a motion for summary judgment. In addition, Defendant Travelers Indemnity Company filed a motion to dismiss, which was not ripe at the time of the hearing, asserting the same grounds for dismissal as those advanced by Aetna and Builders. Accordingly, this Order is dispositive of that motion, as well. Defendants Liberty Mutual Insurance Company and Sedgwick Claims Management Services, Inc. also join in the motions.

1. Motions to Dismiss

A court should grant a motion to dismiss when a plaintiff "would not be entitled to relief under any state of facts that could be proven in support of his claim." Northeast Georgia Cancer Care, LLC v. Blue Cross & Blue Shield of Georgia, Inc., 297 Ga. App. 28, 29 (2009). In ruling on such a motion, the Court must accept as true all of plaintiff's well-pleaded factual allegations, and draw all reasonable inferences in plaintiff's favor. Baker v. McIntosh County Sch. Dist., 264 Ga. App. 509, 509 (2003).

The moving Defendants argue that Plaintiffs' claims are governed by the Act, over which the State Board of Workers' Compensation ("Board") has exclusive

jurisdiction. In support of their argument, Defendants cite O.C.G.A. § 34-9-205, which provides that fees of "physicians, charges of hospitals, charges for prescription drugs, and charges for other items and services under this chapter shall be subject to the approval of the State Board of Workers' Compensation. No...hospital...shall be entitled to collect any fee unless reports required by the board have been made." O.C.G.A. § 34-9-205. On this basis, Defendants contend that the Workers' Compensation Fee Schedule, which sets forth payment guidelines for medical services, is the exclusive authority that governs a fee dispute with a medical service provider, and Plaintiffs are required to exhaust the administrative remedies with the Board, which is statutorily charged with enforcement of the Act.

Plaintiffs counter by pointing out that they are merely trying to enforce a contract, not a provision of the Act. Therefore, this Court, not the Board, has exclusive jurisdiction. See Lumber Transporation, Inc. v. Int'l Indem. Co., 203 Ga. App. 588, 589 (1992) (holding that the court, not the Board, had jurisdiction over whether an insurance contract required an insurer to reimburse an employer for Florida Workers' Compensation-related benefits. The court held that this was a question of contract interpretation, not a question regarding the interpretation of the Act.); Fireman's Fund Ins. Co. v. Crowder, 123 Ga. App. 469, 471 (1971) (The Board "is not a court authorized to render judgments on contracts...since it merely determines the amount of compensation and the time of payment in accordance with the Act.").

The Court finds, at this stage, that it is the proper forum to adjudicate the parties' respective positions under a contract, such as the LOA. Although no Georgia authority

is directly on point, the Court has reviewed two cases from other jurisdictions that have addressed similar circumstances. In HealthSouth Medical Center v. Employers Insurance Co., 232 S.W.3d 828, 831 (Tex. Ct. App. 2007), the Court ruled that the state workers' compensation board had exclusive authority to determine a hospital's right to be paid by a network insurer under a contract governing the hospital's inclusion in a "network" in which the insurer was a participant. However, in that case, the payment scheme under the parties' network contract specifically incorporated the state workers' compensation fee schedule. Id. at 829. In contrast, the provision of the LOA at issue here does not reference Georgia's Workers' Compensation Fee Schedule.

Likewise, the contract at issue in Valley Hospital v. LQ Management, LLC, No. L-7362-10, 2011 WL 3425591, *2 (Sup. Ct. N.J. May 25, 2011), which also involved Defendant Aetna, did not include a payment structure that referenced the state's workers' compensation fee schedule. In that case, the court ruled that it had jurisdiction over the amount owed to a hospital by a network insurer under a contract with Aetna. Id. Although "[t]he [Board] shall have the exclusive original jurisdiction for all claims for workers' compensation benefits," the Court found that the complaint did not seek payment pursuant to the New Jersey workers' compensation act. Id. "Rather, the complaint states a common law contract claim against the insurance carrier under the... Aetna contract." Id.

Not only is the Valley Hospital case instructive because the contract at issue is similar to the LOA, the Court's analysis is consistent with Georgia authority that distinguishes between claims involving the Act, which are subject to the Board's

jurisdiction, leaving claims involving private contract for court adjudication. See Smart Professional Photocopy Corp. v. Dixon, 216 Ga. App. 825 (1995); Fireman's Fund Ins. Co. v. Crowder, 123 Ga. App. 469 (1971).

At the hearing, counsel for certain Defendant Payors indicated that a contract did not exist between Defendant Payors or Aetna or Plaintiffs. If it is shown at the dispositive motions stage that a contractual relationship does not exist, then the Court may find no basis to continue to exercise jurisdiction over this matter. However, at the pleading stage, the Court finds that it is premature to undergo this analysis. Accordingly, Defendants' motion is **DENIED**.

2. Aetna's Motion for Summary Judgment

A court should grant a motion for summary judgment pursuant to O.C.G.A. § 9-11-56 when the moving party shows that no genuine issue of material fact remains to be tried and that the undisputed facts, viewed in the light most favorable to the non-movant, warrant summary judgment as a matter of law. Lau's Corp., Inc. v. Haskins, 261 Ga. 491, 491 (1991).

Aetna moves for summary judgment, arguing that Plaintiffs have no recourse against it for alleged fee underpayment under the LOA. The LOA provides:

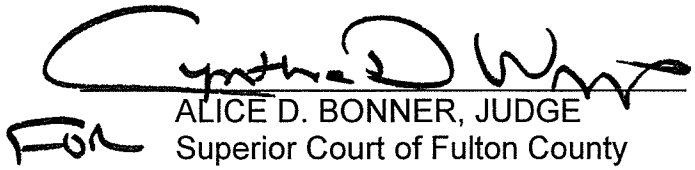
> Providers acknowledge that [Aetna] does not act as a Payor and is not financially responsible for payment for Compensable Services. Providers agree to look to the applicable Payor for Compensable Services and will not assert any claim for compensation against [Aetna] in the event of nonpayment by Payor for Compensable Services for any reason (including Payor's insolvency) or a breach of this Agreement.

Aetna contends that this language bars Plaintiffs from pursuing Count I, which it argues is an attempt to collect from Aetna the balance of medical charges. In contrast, Plaintiffs argue that they are not seeking payment from Aetna for workers' compensation services. Rather, they are asserting breaches of contract against Aetna for failure to correctly process the Hospitals' claims for reimbursement, failure to inform Defendant Payors of the proper rate of reimbursement and failure to properly manage the Network according to negotiated terms.

Aetna cites Constantine v. MCG Health, Inc., 275 Ga. App. 128 (2005), in support of its argument that the non-recourse provision in the LOA bars Plaintiffs from pursuing a breach of contract claim against it. In that case, the Court of Appeals interpreted a similar provision and ruled that it prevented a hospital (like the Plaintiffs in this case) from pursuing a claim against a network member for the breach of contract of a payor.

The Court agrees that the non-recourse provision prevents Plaintiffs from pursuing a claim against Aetna based on a Defendant Payor's failure to pay for services for any reason, even if the Defendant Payor breaches the Agreement. However, the Court finds that the claims asserted against Aetna do not fall within this exclusion. Plaintiffs' claims against Aetna are based on allegations of Aetna's own breaches of its obligations under the LOA, not any purported breaches by Defendant Payors. Accordingly, Aetna's motion is **DENIED**.

SO ORDERED this 14 **day of** June **, 2012.**



FOR ALICE D. BONNER, JUDGE
Superior Court of Fulton County
Atlanta Judicial Circuit

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