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United States District Court

For the Northern District of California

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

CATHOLIC HEALTHCARE WEST-BAY
AREA,

Plaintiff,

v.

SEAFARERS HEALTH & BENEFITS PLAN,

Defendant.

No. C 06-1741 SI

**ORDER GRANTING DEFENDANT’S
MOTION FOR SUMMARY JUDGMENT**

Defendant Seafarers Health and Benefits Plan has filed a motion for summary judgment, which is currently scheduled for a hearing on January 19, 2007. Pursuant to Civil Local Rule 7-1(b), the Court determines that the matter is appropriate for resolution without oral argument, and VACATES the hearing. For the reasons set forth below, the Court GRANTS the motion.

BACKGROUND

I. Factual background

Plaintiff Catholic Healthcare West – Bay Area (“St. Mary’s” or “the Hospital”) is a qualified healthcare provider in the business of providing medical services and is licensed by the State of California to operate a hospital. Complaint ¶ 1. The complaint alleges that St. Mary’s provided medical treatment for a patient, “W.D.”, who was covered under an employer-provided medical insurance plan by defendant Seafarers Health and Benefits Plan (“Seafarers” or “the Plan”). *Id.* ¶ 6. Plaintiff alleges that prior to providing treatment to W.D., St. Mary’s contacted Seafarers and verified coverage for W.D., and that “pursuant to said verification of coverage by Seafarers, necessary medical treatment was

1 administered to patient W.D.” *Id.* Defendant has submitted a “call sheet” showing that a St. Mary’s
 2 employee called the Plan to verify coverage, and that the Plan representative informed the Hospital that
 3 W.D. was eligible for “in-patient hospital, 100% of R&C [reasonable and customary] semi-private room
 4 rate.” *Id.*, Ex. B (call sheet). The call sheet also reflects that the Plan’s representative read a disclaimer
 5 to the St. Mary’s employee. *Id.* According to defendant, that disclaimer states,

6 The benefits and eligibility quoted today reflect the information in our system today. It
 7 is not a guarantee of benefit payment. All claims are processed in accordance with the
 8 plan rules. The plan rules provide specific exclusions and limitations some of which
 9 involve the circumstances which may have caused or contributed to the illness or injury.
 10 For example, no benefits are payable by the plan if the illness or injury is caused by drug
 or alcohol abuse or conduct evidencing a reckless disregard for one’s health and safety.
 Determinations regarding the payment of any claim can only be made after the bill and
 all supporting documents, including pertinent medical records are received and reviewed
 by the Plan.

11 *Id.*, Ex. C (emphasis in original).

12 Plan records indicate that W.D. was admitted to St. Mary’s Medical Center on April 16, 2004,
 13 and after several months of confinement, W.D. was discharged on July 15, 2004. *See* Benoit Decl. ¶ 4.
 14 Two days later on July 17, 2004, W.D. was readmitted to St. Mary’s and finally discharged on August
 15 17, 2004. *Id.* At all relevant times, W.D. was a participant of the Seafarers Plan entitled to health
 16 benefits in accordance with the Plan’s Rules and Regulations. *Id.* ¶ 3. Upon admission to St. Mary’s,
 17 W.D. assigned his benefits under the Plan to St. Mary’s. *Id.* ¶ 4.

18 St. Mary’s submitted a bill for \$947,584.35 for W.D.’s first confinement. *Id.* ¶ 7. A Plan
 19 processor received (“pending”) the claim and made a written request to St. Mary’s for W.D.’s hospital
 20 records, which were provided on or about September 29, 2004. *Id.* at ¶¶ 7-8. The claim was referred
 21 to the Plan’s Catastrophic Case Management Consultant, Michael Camp, M.D. *Id.* Dr. Camp performed
 22 a “Reasonable and Customary Charges Analysis.” Camp Decl. ¶ 5. Dr. Camp concluded that charges
 23 in the amount of \$570,393 exceeded the Plan’s reasonable and customary allowances. *Id.* ¶ 8, & Ex. A.
 24 Dr. Kenneth Miller, the Plan’s Medical Director, also reviewed St. Mary’s bill for “medical necessity.”
 25 Benoit Decl. ¶ 8. Dr. Miller concluded that the length of W.D.’s stay was excessive and recommended
 26 nonpayment for services after June 30, 2004. *Id.* ¶ 9. Based upon the recommendations of Drs. Camp
 27 and Miller, the Plan paid \$317,268.59 of the bill. *Id.* ¶ 10.

28 St. Mary’s submitted a separate bill for \$398,279.22 for W.D.’s second confinement. *Id.* ¶ 11.

1 The Plan followed the same steps processing the second bill as with the first. Dr. Camp concluded that
 2 the bill exceeded the Plan's reasonable and customary charges by \$171,337. Camp Decl. ¶ 9 & Ex. B.
 3 The Plan determined that the treatment provided to W.D. during the second confinement was medically
 4 necessary and that the length of stay was appropriate. Benoit Decl. ¶ 11. The Plan paid \$226,942.22
 5 of the second bill. *Id.*

6 St. Mary's exercised its right of appeal to the Plan's Board of Trustees by submitting two letters
 7 dated November 4, 2004 and November 16, 2004. Benoit Decl. ¶ 12, Ex. F, G. In response, the Plan
 8 contracted with an independent physician to review the claims. *Id.* ¶ 13. The Plan retained Robin L.
 9 Kaplan, M.D. to perform an independent review of both claims. *Id.* According to defendant, Dr. Kaplan
 10 was not involved in the original determination, "nor is he a subordinate of any of the Plan professionals."
 11 *Id.* ¶ 13.

12 Dr. Kaplan examined various records, as well as the "Reasonable and Customary Charge
 13 Analysis" for both confinements. *Id.* ¶ 14, Ex. H, I (Kaplan's reports). With regard to both
 14 confinements, Dr. Kaplan approved of Dr. Camp's analysis of what charges were reasonable and
 15 customary. *Id.* However, Dr. Kaplan concluded that W.D.'s in-patient treatment from July 1, 2004
 16 through July 8, 2004 was medically necessary. *Id.*, Ex. H. at 2-3. Pursuant to Dr. Kaplan's
 17 recommendation, the Plan made a supplemental payment to St. Mary's in the amount of \$49,787.32,
 18 leaving a total disputed unpaid balance of \$751,865.44. *Id.* ¶ 15.

19 By letter dated March 3, 2005, St. Mary's filed a second appeal regarding the first confinement.
 20 *Id.* ¶ 16, Ex. J. The Trustees denied this appeal by letter dated July 11, 2005. *Id.* ¶ 16, Ex. K.

22 **II. Procedural background**

23 Plaintiff filed this action on January 25, 2006, in the Superior Court for the County of San
 24 Francisco. The complaint alleged claims for breach of implied contract, negligent misrepresentation,
 25 promissory estoppel, quantum meruit, and "indebitatus assumpsis (for work, labor, services, and
 26 materials)," and sought the balance of the unpaid bills St. Mary's submitted to the Plan.

27 On March 7, 2006, defendant removed this case to this Court on the ground that plaintiff's claims
 28 were preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C.

1 §§ 1001 *et seq.* On July 14, 2006, plaintiff filed a motion to remand this case to state court. In an order
 2 filed August 16, 2006, the Court denied the motion to remand, holding that plaintiff's claims "relate to"
 3 ERISA. The Court held,

4 There is no dispute that W.D.'s insurance plan is an employee benefit plan under ERISA.
 5 Although plaintiff does not elaborate on what it means by the "simple agreement"
 6 between the parties that Seafarers allegedly breached, presumably plaintiff is referring
 7 to St. Mary's confirmation of medical coverage for W.D., and Seafarers' "agreement"
 8 to pay for expenses under W.D.'s plan. *See* Complaint ¶ 21 ("As a direct and proximate
 9 result of Seafarers' . . . assurances and representations that the patient W.D. had health
 10 coverage with them, from which payment would be made for all of St. Mary's usual and
 11 customary charges for the medical care rendered to patient W.D. as described above, St.
 12 Mary's provided medically necessary services, supplies and/or equipment to patient
 13 W.D."); *id.* ¶ 18 ("[Defendants] negligently made false representations to St. Mary's
 14 without reasonable grounds for doing so that Seafarers . . . would fully pay St. Mary's
 15 *usual and customary charges* for rendering medical care to patient W.D. as described
 16 above.") (emphasis added). In order to evaluate plaintiff's claims, the fact finder would
 17 necessarily be required to interpret W.D.'s policy to determine what expenses were
 18 covered.

12 August 16, 2006 Order at 4. The Court also distinguished *The Meadows v. Employers Health Insurance*,
 13 47 F.3d 1006 (9th Cir. 1995), because in *The Meadows*, the plaintiff health care provider treated a
 14 patient who was not covered by an ERISA plan. *See id.* at 4-5 (discussing *The Meadows* and other cases
 15 relied on by plaintiff).

17 LEGAL STANDARD

18 Summary adjudication is proper when "the pleadings, depositions, answers to interrogatories,
 19 and admissions on file, together with affidavits, if any, show that there is no genuine issue as to any
 20 material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P.
 21 56(c).

22 In a motion for summary judgment, "[if] the moving party for summary judgment meets its initial
 23 burden of identifying for the court those portions of the materials on file that it believes demonstrate the
 24 absence of any genuine issues of material fact, the burden of production then shifts so that the non-
 25 moving party must set forth, by affidavit or as otherwise provided in Rule 56, specific facts showing that
 26 there is a genuine issue for trial." *See T.W. Elec. Service, Inc., v. Pac. Elec. Contractors Ass'n*, 809 F.2d
 27 626, 630 (9th Cir. 1987) (citing *Celotex Corp. v. Catrett*, 477 U.S. 317, 106 S. Ct. 317 (1986)). In
 28 judging evidence at the summary judgment stage, the Court does not make credibility determinations

1 or weigh conflicting evidence, and draws all inferences in the light most favorable to the non-moving
 2 party. *See T.W. Electric*, 809 F.2d at 630-31 (citing *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio*
 3 *Corp.*, 475 U.S. 574, 106 S. Ct. 1348 (1986)); *Ting v. United States*, 927 F.2d 1504, 1509 (9th Cir.
 4 1991). The evidence presented by the parties must be admissible. Fed. R. Civ. P. 56(e). Conclusory,
 5 speculative testimony in affidavits and moving papers is insufficient to raise genuine issues of fact and
 6 defeat summary judgment. *Thornhill Publ'g Co., Inc. v. GTE Corp.*, 594 F.2d 730, 738 (9th Cir. 1979).

8 DISCUSSION

9 I. Standard of review

10 The Supreme Court has held that denials of benefits under ERISA are reviewed de novo by the
 11 district court “unless the benefit plan gives the administrator or fiduciary discretionary authority to
 12 determine eligibility for benefits or to construe the terms of the plan.” *Firestone Tire and Rubber Co.*
 13 *v. Bruch*, 489 U.S. 101, 115 (1989). “[F]or a plan to alter the standard of review from the default of de
 14 novo to the more lenient abuse of discretion, the plan must unambiguously provide discretion to the
 15 administrator.” *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 963 (9th Cir. 2006) (en banc) (citing
 16 *Kearney v. Standard Insurance Co.*, 175 F.3d 1084, 1090 (9th Cir. 1998)).

17 Here, the Plan is governed by a Board of Trustees in accordance with the Rules of the Plan. *See*
 18 DiPrisco Decl. ¶ 9. The Plan’s Agreement and Declaration of Trust grants the Trustees “the exclusive
 19 and absolute authority and sole discretion to adopt, implement, and interpret Plan Rules.” *Id.*, Ex. A at
 20 Article V, ¶ 12. “[T]he Trustees are authorized to determine the nature of, and eligibility for benefits,
 21 and to adopt Regulations for the provisions of said benefits.” *Id.* at Article III, ¶ 1. Moreover, the Plan
 22 Rules and Regulations state, “[t]he decision of the Trustees, or a designated Committee of Trustees, shall
 23 be final and binding on all parties.” *Id.*, Ex. B at Article 2, Section V ¶ 4.

24 The Ninth Circuit has held that similar wording granting the power to interpret plan terms and
 25 to make final benefits determinations confers discretion on the plan administrator. *See, e.g., Abatie*, 458
 26 F.3d at 965 (plan granted administrator “full and final” authority to interpret terms of plan and eligibility
 27 for benefits, stated that authority “rests exclusively” with administrator); *Grosz-Salomon v. Paul Revere*
 28 *Life Ins. Co.*, 237 F.3d 1154, 1159 (9th Cir. 2001) (plan provided administrator “has the full, final,

1 conclusive and binding power to construe and interpret the policy under the plan . . . [and] to make
2 claims determinations”).

3 Plaintiff does not address the standard of review in its opposition. Instead, the opposition largely
4 rehearses plaintiff’s unsuccessful motion for remand. For the reasons noted *supra* in the Background
5 section and in the Court’s August 16, 2006 order, the Court finds plaintiff’s contentions lack merit.
6 Accordingly, the Court holds that the abuse of discretion standard applies in this case.¹

8 **II. Application of standard of review**

9 The abuse of discretion standard requires reversal of the Plan’s determinations if they are
10 arbitrary and capricious. *See Schikore v. BankAmerica Supplemental Retirement Plan*, 269 F.3d 956,
11 961 (9th Cir. 2001). “A plan administrator’s decision to deny benefits must be upheld under the abuse
12 of discretion standard if it is based upon a reasonable interpretation of the plan’s terms and if it was
13 made in good faith.” *McDaniel v. Chevron Corp.*, 203 F.3d 1099, 1113 (9th Cir. 2000). The question
14 is not “whose interpretation of the plan documents is most persuasive, but whether the . . . interpretation
15 is unreasonable.” *Canseco v. Construction Laborers Pension Trust*, 93 F.3d 600, 606 (9th Cir. 1996)
16 (citations and internal quotations omitted).

18 **A. “Reasonable and customary charge”**

19 The Plan defines “reasonable and customary charge” as follows:

21 ¹ In *Abatie*, the Ninth Circuit also stated, “[w]e read *Firestone* to require abuse of discretion
22 review whenever an ERISA plan grants discretion to the plan administrator, but a review informed by
23 the nature, extent, and effect on the decision-making process of any conflict of interest that may appear
24 in the record. This standard applies to the kind of inherent conflict that exists when a plan administrator
25 both administers the plan and funds it, as well as to other forms of conflict.” *Abatie*, 458 F.3d at 967.
26 However, in *Pinto v. Reliance Standard Life Insurance Company*, 214 F.3d 377 (3d Cir. 2000), the court
27 explained that there is no conflict where the employer establishes a plan, pays fixed contributions, and
28 creates a benefits committee with authority to interpret the plan’s terms and administer benefits. *Id.* at
383.

26 Here, the Plan is a “multi-employer labor-management trust fund which is funded solely through
27 employer contributions.” DiPrisco Decl. ¶ 2. The rate of contribution is based upon the
28 recommendation of Plan actuaries and is negotiated between signatory employers and the union. *Id.* The
Plan is a non-profit entity and all of its assets are held in trust and used for the payment of benefits and
related administrative costs. *Id.* Thus, there is no conflict of interest, and the Court applies a
“straightforward abuse of discretion analysis.” *Abatie*, 458 F.3d at 968.

1 The rate recommended by professionals who have researched medical costs throughout
 2 the United States, or the actual cost of a medical service or supply, whichever is lower.
 3 Such recommendations are based upon the relative value of a particular health care
 service as compared to other procedures, and the cost of equivalent services in the
 geographic region where the service was provided.

4 DiPrisco Decl. Ex. B, Definitions ¶ 17. Defendant has submitted the declaration of Dr. Camp in which
 5 he explains the methodology he used to determine the “reasonable and customary” charges. Dr. Camp
 6 states,

7 The following methodology is utilized for all claims that I review for the Plan. I used the
 8 Igenix Medical Data Research Reasonable and Customary Charge Database (otherwise
 known as MediCode) to determine the reasonable and customary charges for medical
 9 services and procedures as categorized by the Current Procedural Terminology (“CPT”)
 Code. CPT Code is an American Medical Association uniform designated descriptor of
 10 medical services, supplies and materials. MediCode is a region-specific reasonable and
 customary charge database organized by zip-code. During 2004, the Plan allowed
 11 payment at the 90th percentile of what MediCode specifies as “reasonable and
 customary.”

12 For pharmaceuticals and supplies, I used the 2004 edition of the Red Book, published by
 Thomson Healthcare to determine the Average Wholesale Price (AWP). For medical
 13 supplies not included in the Red Book, I allowed a minimum of twice the wholesale cost
 or price of the supplies, as determined by the manufacturer’s invoice or price quotes from
 14 providers of such supplies.

15 Camp Decl. ¶¶ 6-7. Dr. Kaplan’s reports regarding the appeals of the two bills state that “[t]he
 16 methodology [Dr. Camp] employed is widely accepted and is standard for this type of analysis,” Benoit
 Decl. Ex. G at 2-3 (first confinement), and “[Dr. Camp’s] methodology was sound and was not
 17 categorically refuted by Mr. Williams in his letter of appeal.” *Id.*, Ex. H at 1-2 (second confinement).

18 Plaintiff asserts that there is a dispute of fact regarding what is “reasonable and customary,” and
 19 has submitted the declaration of H.E. Frech, III, Ph.D. Dr. Frech criticizes Dr. Camp’s methodology,
 20 stating *inter alia*, that Dr. Camp “does not state whether his determination of ‘reasonable and customary’
 21 was made under some traditional definition of terms within the hospital reimbursement marketplace or
 22 some other marketplace”; that Dr. Camp “provides no indication that he accounted for any of St. Mary’s
 23 Medical Center’s unique scope of services and cost structure when determining a ‘reasonable’
 24 reimbursement for the claims at issue”; and that “Seafarer’s methodology . . . does not follow any
 25 traditional definitions that are used within the hospital reimbursement industry.” Frech Decl. ¶¶ 4, 6,
 26 7. Defendant responds that Dr. Frech’s critique is irrelevant because the law does not require the Plan
 27 to adopt plaintiff’s preferred definition of “reasonable and customary,” but only that the Plan’s
 28

1 interpretation of “reasonable and customary” is reasonable and in good faith.

2 The Court agrees with defendant that the question is not “whose interpretation of the plan
3 documents is most persuasive, but whether the . . . interpretation is unreasonable.” *Canseco*, 93 F.3d at
4 606. The Court concludes that Plan’s determination should be upheld because the Plan decided upon
5 a “rate recommended by a professional” – Dr. Camp – who “researched medical costs throughout the
6 United States” through his usage of MediCode and the Red Book, and who made a recommendation
7 “based upon the relative value of a particular health care service as compared to other procedures, and
8 the cost of equivalent services in the geographic region where the service was provided.” Plaintiff has
9 not shown that the Plan’s reliance on this methodology was unreasonable or in bad faith. *See McDaniel*,
10 203 F.3d at 1113-14.

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12 **B. “Medically necessary”**

13 The Plan states, in relevant part:

14 The Plan will not pay benefits for treatments or procedures that it determines are not
15 medically necessary. This exclusion includes, but is not limited to . . . treatment that
16 exceeds the level or length of care, treatment or supply that exceeds that which are
needed to provide safe and adequate care and treatment.

17 DiPrisco Decl. Ex. B, Other Limitations ¶ B. Through the initial review of Dr. Miller, and the appellate
18 review of Dr. Kaplan, the Plan determined that a portion of W.D.’s initial confinement was not
19 medically necessary. The record before the Court does not contain Dr. Miller’s report. However,
20 defendant has submitted a copy of Dr. Kaplan’s report, which states, in relevant part:

21 The clinical progress notes from 7/1/04 through 7/8/04 [a period originally deemed not
22 medically necessary by Dr. Miller] document ongoing clinical problems that, in my
professional opinion, support the medical necessity and appropriateness of continued
acute inpatient services on those dates [discussing specific clinical progress notes].

23 The progress notes and physicians orders dating from 7/9/04 to 7/15/04 document overall
24 stability and slow but steady improvement in [W.D.’s] clinical status, with
discontinuation of antibacterial antibiotic therapy, increased in activity level and
hemodynamic and hemotologic stability. In contrast to the period between 7/1/04 and
25 7/8/04, when the platelet level dipped as low as 2000 and uncertainty prevailed as to the
status of the sinus infection, from 7/9/04 onward the platelet count remained above
26 11,000 and there was clear evidence that the sinus infection was responding to antifungal
treatment.

27 Given the patient’s stormy inpatient course prior to [7/8/04], it seems entirely
28 appropriate to have proceeded as deliberately as his attending physicians had to that
point. In contrast, however, once the decision to cancel surgery was made, the need to

1 continue treatment in hospital was no longer apparent, or adequately documented.
2 Therefore, in my professional opinion, acute inpatient services were not appropriate or
medically necessary from 7/9/04 onward.

3 Benoit Decl. Ex. H at 2-3.

4 The Court concludes that Plan did not act in an arbitrary and capricious manner when it
5 determined that W.D.'s treatment from July 9, 2004 through July 15, 2004 was not medically necessary.
6 As an initial matter, the Court notes that plaintiff does not even address this issue in its opposition.
7 Regardless, the Court finds that Dr. Kaplan's report shows that he reviewed relevant documents in
8 connection with his assessment of W.D.'s first confinement, and he provided a detailed explanation
9 based upon those records of why the acute inpatient services between July 9, 2004 and July 15, 2004
10 were not medically necessary. The Plan's decision to deny coverage for this time period must be upheld
11 because it was "based upon a reasonable interpretation of the plan's terms" and "was made in good
12 faith." *McDaniel*, 203 F.3d at 1113.

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14 **III. Evidentiary objections**

15 Plaintiff objects that defendant's evidence regarding the Plan is irrelevant because plaintiff is not
16 asserting any claims under ERISA. For the reasons stated *supra*, the Court rejects that contention.
17 Moreover, much of this evidence is already part of the record in connection with plaintiff's motion for
18 remand, and plaintiff did not object at that time. Plaintiff also objects to defendant's declarations under
19 Federal Rule of Evidence 403. The Court finds these objections lack merit, as none of the statements
20 at issue are confusing, misleading or prejudicial. Finally, the Court rejects plaintiff's hearsay objections
21 to the Benoit declaration, and finds that Dr. Camp may testify as a percipient witness.

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CONCLUSION

For the foregoing reasons and good cause shown, the Court GRANTS defendant's motion for summary judgment. (Docket No. 35). The Court DENIES plaintiff's request for judicial notice of unpublished cases. (Docket No. 47). The Court OVERRULES plaintiff's evidentiary objections. (Docket Nos. 51, 52, and 53).

IT IS SO ORDERED.

Dated: January 18, 2007



SUSAN ILLSTON
United States District Judge

United States District Court

For the Northern District of California

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