

NYU Langone Hosps. v Aetna Health, Inc.
2021 NY Slip Op 31359(U)
April 23, 2021
Supreme Court, New York County
Docket Number: 155770/2018
Judge: Debra A. James
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0 SUPREME COURT OF THE STATE OF NEW YORK NEW YORK COUNTY

PRESENT: HON. DEBRA A. JAMES PART IAS MOTION 59EFM

Justice

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NYU LANGONE HOSPITALS, Plaintiff,

- v -

AETNA HEALTH, INC. and JOHN DOES Defendants.

INDEX NO. 155770/2018 MOTION DATE 06/04/2020 MOTION SEQ. NO. 003

DECISION + ORDER ON MOTION

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The following e-filed documents, listed by NYSCEF document number (Motion 003) 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 107, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 254

were read on this motion to/for SUMMARY JUDGMENT (AFTER JOINDER)

ORDER

Upon the foregoing documents, it is ORDERED that plaintiff's motion for summary judgment is DENIED, without prejudice; and it is further

ORDERED that defendant's cross-motion for sanctions is DENIED.

DECISION

In this dispute over health insurance reimbursement, plaintiff hospital moves for summary judgment. At issue in this case are the amount of payments allegedly due on over 3800 health insurance claims, nearly 3500 challenged by the plaintiff

and another approximately 350 raised by the defendant by the way of counterclaim, totaling over \$25 million.

Plaintiff hospital brings this suit alleging breach of contract by defendant insurer arguing that defendant insurer has failed to pay for medical services provided to defendants' insureds under a July 1996 Hospital Service Agreement (HSA) which, as amended, governs the parties' relationship as is relevant to the claims asserted here.

The plaintiff moves for summary judgment, arguing that the evidence adduced demonstrates that it has established a prima facie claim of breach of contract as it provided services to the insureds and asserts that defendant has failed to pay for those services as required by the HSA governing such payment.

The defendant not surprisingly disagrees, opposes the motion, and brings a cross-motion for sanctions. Defendant argues that consideration of the thousands of claims presented in this action present a highly complex undertaking for the court requiring individualized analysis and that plaintiff has failed to make a prima facie case that there are no factual issues outstanding including issues of medical necessity, whether the contract requires certain authorization procedures as a condition precedent for payment, and the amount of any payment owed. Defendant argues sanctions are appropriate

because plaintiff's motion is premature and has unduly delayed this action.

The court shall deny the motion without prejudice to renew and shall also deny the cross-motion for sanctions. As agreed by the parties, as to the breach of contract claim, the "elements of such a claim include the existence of a contract, the plaintiff's performance thereunder, the defendant's breach thereof, and resulting damages." Harris v Seward Park Hous. Corp., 79 AD3d 425, 426 (1st Dept 2010). Contrary to plaintiff's assertions, the documentation submitted on this motion is insufficient to carry its burden of establishing breach. Each insurance claim as delineated by the HSA represents a separate performance under the contract and as argued by the defendant, the currently submitted summaries are insufficient without more to demonstrate a prima facie case. However, contrary to defendant's assertion, there is no reason that these claims cannot be joined for disposition in a single action where the plaintiff and defendant are common to all claims and there is a single contract governing the parties' transactions and relationship. Contrast Mount Sinai Hosp. v Motor Veh. Acc. Indem. Corp., 291 AD2d 536, 536 (2d Dept 2002) (severance was appropriate where there was no common contract of insurance and claims had no relation or similarity to each other, other than non-payment). Nor is there any basis to impose sanctions for

plaintiff's assertion of an argument that there were claims that could be summarily disposed in this action.

The court denies plaintiff's motion, without prejudice, because ultimately the contractual interpretive issues that may be at play in application of the terms of the HSA as it pertains to the claims at issue in the case could lend themselves to summary disposition as matters of law. As stated by the Court,

The construction and interpretation of an unambiguous written contract is an issue of law within the province of the court, as is the inquiry of whether the writing is ambiguous in the first instance. Where the language is free from ambiguity, its meaning may be determined as a matter of law on the basis of the writing alone without resort to extrinsic evidence. The objective of a court asked to interpret contract language is to determine the parties' intention as derived from the language they employed in the contract. Thus, when interpreting a contract, the court should arrive at a construction which will give fair meaning to all of the language employed by the parties to reach a practical interpretation of the expressions of the parties so that their reasonable expectations will be realized.

Master-Built Const. Co., Inc. v Thorne, 22 AD3d 535, 535-36(2d Dept 2005) (citations and internal quotations omitted).

Therefore, based upon the claims and counterclaims asserted by the parties, this court, upon proper application, must first determine, where the parties disagree amongst themselves, whether the HSA is ambiguous as to the issues between the parties as to the relevant claim(s), and whether the court is able to exercise its function of contract interpretation, as a matter of law. Following such a determination, which must arise

out of the claims present in this action, the next inquiry would be the application of the contract to the disputed claims. Those claims where it is either established or agreed that the facts as presented on an evidentiary basis are not in dispute could then be resolved by the application of the interpreted HSA. Where, after considering the respective parties appropriate proof burden of proof, disputed issues of fact on individual claims as established by the introduction of evidentiary matter remain, those issues would need to be tried as suggested by the defendant prior to the application of the court's contract interpretive function.

The court, reviewing the parties' submissions on this motion, finds that not only is the proffered evidentiary matter not in admissible form, there is also insufficient definition based upon the individual claims presented for adjudication as to the contractual terms alleged to be applicable in determining whether plaintiff's claims of breach and defendant's defenses thereto are valid.

Accordingly, the court shall deny the current applications and direct the parties to complete any necessary discovery and otherwise proceed in accordance with this decision in the manner set forth in the Order resolving Motion Seq. No. 006.

Debra A. James

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4/23/2021

DATE

DEBRA A. JAMES, J.S.C.

CHECK ONE:

CASE DISPOSED

NON-FINAL DISPOSITION

GRANTED

DENIED

GRANTED IN PART

OTHER

APPLICATION:

SETTLE ORDER

SUBMIT ORDER

CHECK IF APPROPRIATE:

INCLUDES TRANSFER/REASSIGN

FIDUCIARY APPOINTMENT

REFERENCE