

**Bronx-Lebanon Hosp. Ctr. v New York State Catholic  
Health Plan, Inc.**

2025 NY Slip Op 34216(U)

November 6, 2025

Supreme Court, Bronx County

Docket Number: Index No. 24572/2013E

Judge: Paul L. Alpert

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SUPREME COURT OF THE STATE OF NEW YORK  
BRONX COUNTY

PRESENT: HON. PAUL L. ALPERT PART IA-26  
*Justice*

-----X  
BRONX-LEBANON HOSPITAL CENTER INDEX NO. 24572/2013E  
Plaintiff, MOTION SEQ. NO. 8

- v -  
NEW YORK STATE CATHOLIC HEALTH PLAN, INC., DECISION + ORDER ON  
Defendant. MOTION AFTER REMAND

-----X  
The following e-filed documents, listed by NYSCEF document number (Motion 8) 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 194, 195, 196, 197, 198, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 218, 224, 225, 226, 227 were read on this motion to/for JUDGMENT - SUMMARY

PAUL L. ALPERT, J.S.C.

In this action for breach of contract, defendant New York State Catholic Health Plan, Inc., doing business as Fidelis Care New York (Fidelis) previously moved pursuant to CPLR 3212 for partial summary judgment dismissing the second and third causes of action alleged by plaintiff Bronx-Lebanon Hospital Center (the Hospital) for breach of an express or implied-in-fact contract and unjust enrichment, and dismissing “those portions of the Complaint predicated upon [Fidelis’] allegedly improper denial and/or underpayment of medical reimbursement claims that [the Hospital] failed to timely challenge through the contractually-prescribed dispute resolution procedures” (notice of motion, NYSCEF Doc. No. 174). By decision and order dated February 8, 2024, this court denied the motion, holding that issues of fact existed regarding Fidelis’ evidence submitted in support of the motion (NYSCEF Doc. No. 216). The court assumes familiarity with the background of this matter as set forth therein.

Fidelis appealed this court’s decision. By decision and order dated February 27, 2025, the Appellate Division, First Department modified this court’s decision to dismiss the second and third causes of action (*Bronx-Lebanon Hosp. Ctr. v New York State Catholic Health Plan, Inc.*, 235 AD3d 574, 575 [1st Dept 2025]). Further, the court found that no issue of fact existed regarding the compilation of Fidelis’ case records presented with the original motion (*id.*). The court remanded the matter for this court to resolve “substantive arguments regarding contractual terms in the provider agreements as well as the proper interpretation of Insurance Law article 49” (*id.*). Thereafter, this court received supplemental briefing from the parties regarding the remaining issues to be determined.

As briefed by the parties, the remaining issues are two-fold: (1) whether the agreements between the parties mandate that before commencing an action for nonpayment, the Hospital follow the internal appeals process for all claim denials or denials just based on lack of medical

necessity, and (2) whether Article 49 of the Insurance Law voids the parties' agreements to the extent that they preclude the Hospital from commencing an action for Fidelis' nonpayment if the Hospital fails to follow the internal appeal process.

Article 49 governs the utilization review process, whereby patients and health care providers such as the Hospital can appeal denials of claims by insurance companies and HMOs, which are required to develop such a process (Insurance Law §§ 4903, 4904). The statute provides that "[t]he rights and remedies conferred in this article upon enrollees and health care providers shall be cumulative and in addition to and not in lieu of any other rights or remedies available under law" (Insurance Law § 4907). Moreover, "[a]ny agreement which purports to waive, limit, disclaim, or in any way diminish the rights set forth in this article . . . shall be void as contrary to public policy" (Insurance Law § 4906 [a]).

In determining whether a provider or patient must resort to the external review process described in Insurance Law §§ 4910-4917, the Appellate Division has held that such a requirement would be contrary to the remedies provision described in Insurance § 4907 above (*Schulman v Group Health Inc.*, 39 AD3d 223, 224 [1st Dept 2007]; *Nenno v Blue Cross & Blue Shield of W. New York*, 303 AD2d 930, 932 [4th Dept 2003]). No reason exists why this conclusion should not apply to a patient or provider who fails to take an internal appeal as well. The Insurance Law also supports this conclusion, as the provisions regarding the internal appeal process state that "[a]n insured, the insured's designee and, in connection with retrospective adverse determinations, an insured's health care provider, **may** appeal an adverse determination rendered by a utilization review agent" (Insurance Law § 4904 [emphasis added]; *People v Golo*, 26 NY3d 358, 362-63 [2015] [interpreting "shall" as mandatory and "may" as permissive in statutory language]).

The Insurance Law provisions discussed above, however, do not entirely answer the questions posed by this action. Article 49 specifically applies to adverse determinations, which are defined as "determination[s] by a utilization review agent that an admission, extension of stay, or other health care service, upon review based on the information provided, is not medically necessary" (Insurance Law § 4900 [a]). Accordingly, adverse determinations for reasons other than medical necessity are not covered by Article 49. The court notes that the Public Health Law supports this conclusion, as it includes a procedure for denials of claims for reasons other than medical necessity (Public Health Law § 4408-a [stating that "enrollees shall be entitled to seek a review of determinations by the organization other than determinations subject to the provisions of article forty-nine of this chapter"]<sup>1</sup>). Unlike the procedure for medical necessity denials, the procedure for other denials does not include the remedies provision set forth at Insurance Law § 4907.

The Hospital argues that Fidelis did not need to include denials other than medical necessity in its appeal process, but since it has done so the Hospital should receive the protection of Article 49 for all denials. However, this argument runs afoul of the clear statutory language cited above. Moreover, *City of Ithaca v Ithaca St. Ry. Co.*, which the Hospital cites, holds only that "a party may waive the benefit of a statute and may assume obligations in addition or beyond the statutory obligations which would otherwise control" (145 AD 675, 677 [3d Dept 1911]). Here, Fidelis has not waived any statutory benefit.

<sup>1</sup> Article 49 of the Public Health Law is substantially identical to Article 49 of the Insurance Law.

Moreover, the court need not declare the entire dispute resolution system in the provider agreements void. Over the course of the parties' business relationship, they have entered into three different provider agreements, each of which contains substantially the same severability provision: "[t]he provisions of this Agreement are severable, and, if any provision of this Agreement is held to be invalid, illegal or otherwise unenforceable, in whole or in part, in any jurisdiction, said provision or part thereof shall, as to that jurisdiction be ineffective to the extent of such invalidity, illegality or unenforceability" (2013 provider agreement, NYSCEF Doc. No. 182, § 11.7; *see also* 2000 provider agreement, NYSCEF Doc. No. 180, § 12.7; 2007 provider agreement, NYSCEF Doc. No. 181, § 12.7). Thus, the court may permissibly void only so much of the dispute resolution provisions in the parties' agreements regarding medical necessity claims (*cf. Perella Weinberg Partners LLC v Kramer*, 230 AD3d 451, 452 [1st Dept 2024] [holding, with respect to noncompete clauses, that "(t)o the extent that defendants argue that the clause is too broad to be enforced as written, the court has the power to sever and grant partial enforcement for an overbroad restrictive covenant" [internal quotation marks and citations omitted]). *Brady v Williams Capital Group, L.P.*, which the Hospital cites, supports this argument (64 AD3d 127, 137 [1st Dept 2009], *affd as mod*, 14 NY3d 459 [2010] [holding that "the appropriate remedy is to sever the improper provision of the arbitration agreement, rather than void the entire agreement"])).

Whether the Hospital may litigate claims denied for reasons other than medical necessity or whether it has waived the right to do so must be determined by the parties' agreements. Each of the provider agreements set forth the following dispute resolution language:

"Any disputes arising out of this Agreement shall be resolved in the first instance, exclusively through the grievance process for Providers as set forth in the Provider Manual. Any appeals permitted by such grievance process, including claimed defects in the grievance process itself; shall be determined exclusively by binding arbitration before a single arbitrator selected and serving under the arbitration rules of the American Health Lawyers Association (AHLA) Alternative Dispute Resolution Service. Any such arbitration shall be held in the county in which the Provider maintains its principal place of business, unless special evidentiary circumstances as determined by the arbitrator, require another venue. Such arbitration shall be the exclusive remedy hereunder" (2013 provider agreement, § 11.6; *see also* 2000 provider agreement, § 12.6; 2007 provider agreement, § 12.6).

By contrast to the uniformity of the provider agreements, Fidelis' grievance process as set forth in the provider manuals has varied significantly throughout the parties' relationship. While there has always been a process set forth to review medical necessity denials, initially the only "administrative denials" mentioned in the provider manual were those where the Hospital had "to appropriately communicate with Fidelis regarding the proposed or on-going treatment" (2007 provider manual, NYSCEF Doc. No. 183, § 13.6). Moreover, appeals of both medical necessity and administrative denials were entirely permissive (*id.*, §§ 13.1 ["Providers . . . **may** appeal Fidelis' decisions regarding the medical necessity of treatment"], 13.6 ["the Provider **may** seek reconsideration of an administrative denial"] [emphasis added]). Between the 2007 manual and the January 1, 2014 manual, Fidelis added additional categories of claims to the list of

administrative denials, but all appeals remained permissive (October 2010 provider manual, NYSCEF Doc. No. 184, §§ 13.1, 13.6; August 2011 provider manual, NYSCEF Doc. No. 185, §§ 13.1, 13.6; January 2012 provider manual, NYSCEF Doc. No. 186, §§ 13.1, 13.6; V13.0 provider manual, NYSCEF Doc. No. 187, §§ 13.1, 13.6; January 1, 2014 provider manual, NYSCEF Doc. No. 188, §§ 13.1, 13.6).

It was only in the provider manual effective October 15, 2015 that Fidelis altered the language of its appeal process, stating that “[p]roviders . . . **shall** appeal Fidelis Care's decisions regarding the medical necessity of treatment . . . if they disagree with a denial based on lack of medical necessity” (October 2015 provider manual, NYSCEF Doc. No. 189, § 13.1 [emphasis added]). The appeal process for administrative denials was similarly amended (*id.*, § 13.6 [“If Fidelis Care denies a request for authorization of services and the basis for the denial is not lack of medical necessity, the provider, member, or members designee **shall** appeal the denial if they disagree with the denial”] [emphasis added]). Accordingly, where the appeal process was entirely permissive up until October 15, 2015, the court cannot find that the Hospital has waived court review of unappealed denials of claims filed prior to that date (*Homapour v Harounian*, 200 AD3d 575 [1st Dept 2021] [holding that a waiver “must be explicit, unmistakable, and unambiguous, and cannot be inferred by a doubtful or equivocal act”] [internal citations and quotation marks omitted]).

Applying the above to the list of unappealed claims that are the subject of this motion, the court finds as follows. First, Article 49 of the Insurance Law prohibits the waiver of any claim based on medical necessity, regardless of when it occurred, and the dispute resolutions are void as applied to such claims. Second, any claims denied for reasons other than medical necessity that the Hospital made prior to October 15, 2015 are also still valid, as the permissive nature of Fidelis’ claims process prior to that point precludes any claim of waiver. *Morningstar Care Ctr. v Zucker* (2016 WL 5394720, 2016 US Dist LEXIS 131852 [ND NY, Sep. 27, 2016, No. 5:15-CV-1470 (GTS/DEP)]), which Fidelis cites, does not require a contrary result, as that case did not involve the provisions discussed above, nor did the court consider the applicability of Article 49.

Once the amended provider manual took effect on October 15, 2015, however, all denials for reasons other than medical necessity were subject to the mandatory internal appeal process, and the Hospital has waived any unappealed “administrative denials” from that date onward. The Hospital argues that the Plan cannot require it to contract away its right to seek court review of such denials, but provisions requiring alternative dispute resolution prior to or in lieu of suit are enforceable against claims filed without complying with same (*see MCC Dev. Corp. v Perla*, 81 AD3d 474 [1st Dept 2011], *lv denied* 17 NY3d 715 [2011]). *Skolnick v Goldberg*, which the Hospital cites, is unavailing, as there the court considered whether a party to a contract was manipulating its terms to intimidate a third-party from taking legitimate action (297 AD2d 18, 20-21 [1st Dept 2002]). No such facts are present here.

Finally, the Hospital argues that there are issues of fact as to whether the unappealed claims at issue are medical necessity denials or administrative denials. The Hospital relies on a sampling of the claims on which the parties have agreed to hold a representative trial and asserts that the listed denial codes are unclear (sample denials, NYSCEF Doc. No. 225). The court, however, finds the reasons given by Fidelis sufficient to determine whether the denials were based on medical necessity or for administrative reasons.

The court has considered the additional contentions of the parties not specifically addressed herein. To the extent that any relief requested by any movant was not addressed by the court, it is hereby denied.

Accordingly, it is hereby

ORDERED that the motion by New York State Catholic Health Plan, Inc., doing business as Fidelis Care New York for partial summary judgment is granted to the extent that all unappealed denials of claims for reasons other than medical necessity filed from October 15, 2015 through December 31, 2017 are dismissed, and the motion is otherwise denied; and it is further

ORDERED that defendant shall serve a copy of this decision and order on the plaintiff within twenty (20) days of notice of entry.

This constitutes the decision and order of the court.

PAUL L. ALPERT, J.S.C.

11/6/2025

DATE

CHECK ONE:

CASE DISPOSED

GRANTED

DENIED

NON-FINAL DISPOSITION

GRANTED IN PART

OTHER

APPLICATION:

SETTLE ORDER

SUBMIT ORDER

CHECK IF APPROPRIATE:

INCLUDES TRANSFER/REASSIGN

FIDUCIARY APPOINTMENT

REFERENCE