

**UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION**

**REACH AIR MEDICAL SERVICES
LLC, CALSTAR AIR MEDICAL
SERVICES, LLC, GUARDIAN
FLIGHT LLC, MED-TRANS
CORPORATION, and AIR EVAC
EMS, INC.**

Plaintiffs,

V.

**AETNA HEALTH, INC., AETNA LIFE
INSURANCE COMPANY AETNA
HEALTH AND LIFE INSURANCE
COMPANY, and CIGNA HEALTH
AND LIFE INSURANCE COMPANY,**

Defendants.

Civil Action No. 4:23-cv-00805
Hon. Alfred H. Bennett

JURY TRIAL DEMANDED

**PLAINTIFFS' NOTICE OF SUPPLEMENTAL AUTHORITY
AND RESPONSE TO AETNA'S NOTICE OF SUPPLEMENTAL AUTHORITY**

Plaintiffs REACH Air Medical Services, LLC (“REACH”), CALSTAR Air Medical Services, LLC (“CALSTAR”), Guardian Flight, LLC (“Guardian Flight”), Med-Trans Corporation (“Med-Trans”), and Air Evac EMS, Inc. (“Air Evac”) (collectively “Plaintiffs”) file this Notice of Supplemental Authority and Response to Aetna’s Notice of Supplemental Authority (“Aetna’s Notice”) and would respectfully show the Court as follows:

Aetna’s Notice wastes judicial resources by calling this Court’s attention to an irrelevant, unpublished case in *pro se* litigation by a disgruntled patient—*Los Robles Emergency Physicians Medical Group v. Stanford –Franz*, 2:22-cv-9487 (C.D. Cal. Feb. 8, 2024). *Los Robles* has nothing to do with enforcing an IDR award issued in accordance with the NSA’s independent dispute

resolution procedures. Instead, the case involves a patient¹ who, unhappy with an \$856 emergency room bill, undertook “a malicious and vindictive scheme...to confuse the public, disrupt the [provider’s] business, and destroy [the treating physician’s] personal and professional reputation” by, among other things, creating a fictitious business name to divert provider payments to herself. *See* Ex. 1 at p. 2.² When the provider sued to stop her interference, she filed a *pro se* counterclaim asserting multiple “wholly frivolous,” “nonsensical on its face,” “bizarre and baseless” claims. *See* Ex. 2 at pp. 2-3, 8 and 11.³ Unsurprisingly, all were dismissed. *See* Dkt. 60-1.

The *pro se* litigant’s No Surprises Act (“NSA”) claim concerned the provider’s attempts to collect on an \$856 bill, which was all patient responsibility because she had not met her deductible for the plan year. *See* Ex. 1 at pp. 4-6. The underlying medical services were provided on November 7, 2021. *Id.* at p. 5. The NSA became effective for medical services provided on or after January 1, 2022, meaning it did not even apply to this invoice. *See* 45 CFR 149.410. And the deductions by the insurer on the EOB had nothing to do with the NSA or its balance billing protections. *Id.* at p. 6. Regardless, the *pro se* litigant alleged that the provider’s attempt to collect on the entire \$856 invoice was “balance billing fraud” and “upcoding fraud” that somehow violated the NSA. *Id.* at p. 4.

In response, the provider moved to dismiss all claims, asserting that *the patient’s* counterclaims for “violation of the No Surprises Act are barred because there is no private right of

¹ For simplicity, this brief refers to the defendant/counter-claimant as the “patient” although the emergency room services at issue were actually for the defendant’s minor son.

² Attached as Exhibit 1 are relevant excerpts from the pleadings in the *Los Robles* matter. Citations are to the page numbers added to the bottom right of the exhibit.

³ Attached as Exhibit 2 are relevant excerpts from the motion to dismiss briefing in the *Los Robles* matter. Citations are likewise to the page numbers added to the bottom right of the exhibit.

action **for these claims.**” Ex. 2 at p. 2 (emphasis added). Notably, the *pro se* litigant did not even argue to the contrary in her response. *Id.* at p. 6. The court concluded there was no private right of action for the patient’s alleged violation of the NSA **because** there is “an extensive dispute resolution process between insurers and medical providers” and that **the patient** could not use “typical litigation in federal courts.” Dkt. 60-1 at p. 5.

The *pro se* litigation that Aetna provides to this Court is factually and legally inapposite and irrelevant to the case before it, and the Court should disregard it. The *Los Robles* case has **nothing** to do with the enforceability in federal court of an IDR award resulting from the “extensive dispute resolution process” to which the *Los Robles* court directed the disgruntled patient.

If the Court is interested in how another court ruled in a proceeding that actually concerned enforcing IDR awards in federal court, Plaintiffs have only located one such case: *GPS of New Jersey v. Horizon Blue Cross & Blue Shield*, No. 22-cv-6614, 2023 WL 5815821 (D.N.J. Sept. 8, 2023). *See* Ex. 3. This case was issued after Plaintiffs filed their response to Aetna’s motion to dismiss. In *GPS*, a federal court in New Jersey did not hesitate to enforce an IDR award. *See* Ex. 3 at *10. The New Jersey court explained that the language in the NSA “indicates the [IDR] decision is to be ‘final and binding,’ and gives the court authority to confirm the award.” *Id.* Notably, it was the insurer that sought enforcement of the award, which was being challenged by the provider.

There is no split in authority on whether IDR awards are enforceable in federal court. Only one court has considered the issue and it enforced the award. Because it was the insurer seeking to enforce its win, the New Jersey court was not confronted with the issues of what additional compensation, including prejudgment interest, is recoverable when providers must enforce IDR awards that were not timely paid. Those are issues of first impression for this Court.

Dated: February 21, 2024

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Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I certify that on February 21, 2024, a true and correct copy of the foregoing was served electronically on all counsel of record.

/s/ Adam T. Schramek
Adam T. Schramek

Exhibit 1

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

LOS ROBLES EMERGENCY
PHYSICIANS MEDICAL GROUP;
RICHARD BENEDON,

Plaintiffs,

vs.

CARRIE L. STANFORD-FRANZ,
Defendant.

Case No.:

**COMPLAINT FOR DAMAGES AND
INJUNCTIVE RELIEF**

- 1. TRADEMARK INFRINGEMENT
(15 U.S.C. § 1114(1)(A))**
- 2. COMMON LAW TRADEMARK
INFRINGEMENT**
- 3. UNFAIR BUSINESS PRACTICES
(CAL. BUS. & PROF. CODE § 17200)**
- 4. CYBERSQUATTING
(15 U.S.C. § 1125)**
- 5. CONVERSION**
- 6. DEFAMATION**
- 7. FALSE LIGHT INVASION OF
PRIVACY**
- 8. CIVIL HARASSMENT
(Cal. Code. Civ. Pro. § 527.6)**
- 9. INTENTIONAL INFLICTION OF
EMOTIONAL DISTRESS**

DEMAND FOR JURY TRIAL

1 Plaintiffs Los Robles Emergency Physicians Medical Group (“Los Robles”) and
2 Dr. Richard Benedon (“Dr. Benedon”) (collectively, “Plaintiffs”), by and through their
3 undersigned attorneys, allege upon knowledge as to themselves and their own acts and
4 allege upon information and belief as to all other matters, brings this Complaint.

5 INTRODUCTION

6 1. This action concerns a malicious and vindictive scheme by Defendant Carrie
7 L. Stanford-Franz (“Defendant”) to confuse the public, disrupt Los Robles’ business, and
8 destroy Dr. Benedon’s personal and professional reputation—all because Defendant
9 believes she was incorrectly billed for services provided by Los Robles.

10 2. The range and depravity of Defendant’s illegal conduct is breathtaking. Thus
11 far, Defendant has:

- 12 • created multiple business entities, filed a business license, and filed a
13 fictitious business name with the exact same name as Los Robles;
- 14 • created a website with Los Robles’ initials (LREPMG.com) that urges
15 people to contact and harass Dr. Benedon;
- 16 • committed mail fraud by filing a change of address for Los Robles with the
17 U.S. Postal Service;
- 18 • diverted and received checks intended for Los Robles and then indicated she
19 would cash at least one of those checks;
- 20 • opened mail intended for Los Robles that contained private medical
21 information of individuals protected by HIPAA;
- 22 • caused the address to be changed on Los Robles’ bank accounts;
- 23 • defamed Dr. Benedon by writing to third parties in the medical field that he
24 may be addicted to controlled substances and is self-medicating.

25 3. Los Robles and Dr. Benedon have repeatedly requested that Defendant cease
26 and desist from her illegal campaign but to no avail. Consequently, Plaintiffs have no
27 choice but to bring this action.
28

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA- WESTERN DIVISION

LOS ROBLES EMERGENCY) CASE NO: **23-cv-09487-DSF-MARx**
PHYSICIANS MEDICAL GROUP,)
and RICHARD S. BENEDON,) **VERIFIED COUNTERCLAIM FOR**
) **DAMAGES AND INJUNCTIVE**
Plaintiffs/Counter-Defendants.) **RELIEF**

vs.)
) [Answer filed as separate document]
CARRIE L. STANFORD-FRANZ,)
)
)
1. MALICIOUS PROSECUTION
Defendant/Counterclaimant.)

CARRIE L. STANFORD-FRANZ,)
Counterclaimant/Defendant,)

3. **NO SUPPRISES ACT**
[28 U.S.C. § 9816 *et seq.*]

vs.	)	4. NEGLIGENCE
	)	
LOS ROBLES EMERGENCY	)	5. BREACH OF CONTACT
PHYSICIANS MEDICAL GROUP,	)	
and RICHARD S. BENEDON,	)	6. UNFAIR COMPETITION
	)	[Cal. Bus. & Prof. Code § 17200]
Counter-Defendants/Plaintiffs.)	)	

XII. BALANCE BILLING FRAUD

[No Surprises Act]

49. When a medical provider agrees to accept medical insurance, the provider also agrees to be compensated at the pre-arranged rate for the services provided to the insured patient. This is referred to as the “contracted rate” or “allowed amount.”

50. As part of the agreement with the insurance carrier, the provider also agrees to not bill the patient for any deficiency balance from the amount billed by the provider and the “allowed amount” they had agreed to accept from the insurer.

51. Upon closer examination of the Explanation of Benefits (“EOB”) from Blue Shield, it is clear Blue Shield did not allow the full amount for the alleged surgery as billed by the Partnership, notwithstanding the fact the procedure was never performed. *See* Exhibit I attached hereto.

52. Even though the Partnership had agreed to accept Blue Shield and they only allowed a portion of the billed amount, the Partnership sent the full amount to a debt collector for collection. This constitutes a violation of the No Surprises Act.

53. As a result of Defendants’ violation of the No Surprises Act, Plaintiff was harmed.

XIII. CAUSE OF ACTION- NEGLIGENCE

54. As a result of the mislabeled prescription bottle, Franz’ son went without pain management for two weeks while he waited for a surgical appointment

55. As emergency room physicians, the Partnership owes a duty of care to its patients.

56. Prescribing opioids to a minor without examining him falls below the standard of care of emergency physicians.

57. Mislabeled a prescription for opioids can result in injury or death and therefore falls below the standard of care of emergency physicians.

58. The Partnership breached its duty of care owed to Franz and her minor son.

STATEMENT PRINT DATE: 04-25-23

LOS ROBLES EMERGENCY PHYSICIANS
 TAX ID#: 95-3042835
 PO BOX 661147
 ARCADIA CA 91066-1147
 18050 / 6314694

STANFORD, CARRIE
 1997 SHOEMAKER LN
 NEWBURY PARK CA 91320

*This provider does not maintain a charity
 care program, no other reductions are
 applicable at this time.*

PATIENT NAME: SMITH, AUSTIN
 ACCOUNT #: 22525514901

FACILITY SEEN AT: LOS ROBLES REG MED CTR E D

Date	Patient	Description	Code	Amount
11-07-21	AUSTIN	99283 EMERGENCY PHYSICIAN SE	S49.8	367.00
11-07-21	AUSTIN	11 DISCHARGE	S49.8	0.00
11-07-21	AUSTIN	23500 TREAT CLAVICLE FRACTUR	S42.0	489.00
TOTAL CURRENT				856.00

\$ 856.00 assigned to
 PSC Inc for collection

**Pmts/adj credited after assigned
 to PSC: \$ -574.50 11/01/2022**

EXPLANATION OF BENEFITS

This is NOT a Bill

Retain for your records along with any provider bills.

This Explanation of Benefits (EOB) is to notify you that we have processed your claim. It clarifies your payment responsibility or reimbursement.

Your claim information is also available in the My Health Plan section of www.blueshieldca.com. If you have any questions about this document, please call one of our claims representatives at (888) 319-5999.

CLAIM SUMMARY AT A GLANCE

Patient Name: [REDACTED]	
Patient responsibility: (Amount you paid or owe to provider.)	\$807.91
Blue Shield responsibility:	\$0.00
Network savings: (Amount saved by using a network provider.)	\$198.09
Amount billed by Provider:	\$856.00
Your claim was received [REDACTED] and processed in 1 day(s). Deductible Status: [REDACTED]	

DETAIL Provider: [REDACTED]

Preferred Provider No

Service Date	Type of Service and Procedure Number	Amount Billed Provider billed for services	Amount Allowed Used to calculate benefits	Blue Shield Responsibility	Patient Responsibility			Notes
					Non Covered	Deductible You pay provider before we begin payments	Copayment/ Coinsurance	
[REDACTED]	Surgical 2350054	489.00	440.91	0.00	0.00	440.91	0.00	1,2
[REDACTED]	Office Medical 9928357	367.00	367.00	0.00	0.00	367.00	0.00	1
Claim Totals:		\$856.00		0.00	0.00	807.91	0.00	

Notes

- The physician or other health care provider is not part of this plan's provider network. Because this claim is for services rendered in your Health Plans Contracted Facility, you may only be responsible for deductible, copayment and non-covered amounts, if any, noted on this Explanation of Benefits. Please contact us, by calling or writing to the phone number/address indicated on this Explanation of Benefits, if you are billed by the provider for more than the patient responsibility amount indicated on this form.
- The allowable amount has been reduced because the modifier indicates the procedure was performed at a reduced level.

Messages

Your deductible and/or copayment responsibility was based on the allowed amount. However payment is based on the provider's contract with your Health Plan.

Diagnosis and treatment codes billed on this claim and their meanings can be requested by contacting Customer Service.

Thank you for choosing Blue Shield.

To see the extra services and support available to you, go to www.blueshieldca.com.

Exhibit 2

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 and Richard Benedon

**UNITED STATES DISTRICT COURT
 CENTRAL DISTRICT OF CALIFORNIA – WESTERN DIVISION**

**LOS ROBLES EMERGENCY
 PHYSICIANS MEDICAL GROUP;
 RICHARD BENEDON,**

Plaintiffs,

vs.

CARRIE L. STANFORD-FRANZ,
 Defendant.

CARRIE L. STANFORD-FRANZ,
 Counterclaimant

vs.

**LOS ROBLES EMERGENCY
 PHYSICIANS MEDICAL GROUP;
 RICHARD BENEDON,**

Counterdefendants

) Case No.: 2:23-cv-09487-DSF-MAR
)
) **MEMORANDUM OF POINTS AND**
) **AUTHORITIES IN SUPPORT OF**
) **COUNTERDEFENDANTS AND**
) **PLAINTIFFS' MOTION**
) **TO DISMISS [FED. R. CIV. PROC.**
) **12(b)(6)**

) [Notice of Motion and Motion;
 Declaration of Jordan Susman filed
 concurrently herewith]

) Date: February 5, 2024
) Time: 1:30 p.m.
) Courtroom: 7D

counterclaims range from frivolous to nonsensical, and they should be dismissed with prejudice:

- Franz's counterclaim for malicious prosecution is **nonsensical**, because, other than the current action, Plaintiffs have never commenced pursued a legal action against Franz, and Franz has never had a legal action by Plaintiffs terminated in her favor.
- Franz's counterclaims for upcoding fraud and violation of the No Surprises Act are barred because there is no private right of action for these claims. In addition, Franz released any such claims in he settlement with Plaintiffs.
- Franz's counterclaim for negligence is **frivolous** because she was never a patient of Plaintiffs, and the claim was covered by Franz's release.
- Franz's counterclaim for breach of contract fails because there is no allegation that Plaintiffs breached any provision of any agreement
- Franz's counterclaim for violation of Business & Professions Code section 17200 fails because Franz has not alleged that Plaintiffs engaged in any business practices that were unfair or deceptive. In addition, Plaintiffs' purported actions are protected by the litigation privilege.

The Court should dismiss all of Franz's counterclaims with prejudice.

II. RELEVANT FACTS FROM FRANZ'S COUNTERCLAIM

On September 5, 2023, Franz filed the First Action against Plaintiffs. (Counterclaim 2:2-8 and Ex. A thereto).

On October 27, 2023, Plaintiffs and Franz entered into a settlement agreement, in which Plaintiffs made certain representations of value to Franz, and in

1 *Thompson v. Illinois Dept. of Professional Regulation* 300 F.3d 750, 754 (7th Cir.
2 2002) (holding that when a contradiction exists between the allegations and an
3 exhibit, “*the exhibit trumps the allegations*”) (emphasis in original).

4 Plaintiff’s counterclaims against Plaintiffs have not, and cannot, meet these
5 burdens.

6 **V. ARGUMENT**

7 **The Counterclaim Fails to Allege a Claim for Malicious Prosecution**

8 “To establish a claim for the malicious prosecution of a civil proceeding, a
9 plaintiff must plead and prove that the prior action (1) was commenced by or at the
10 direction of the defendant and was pursued to a legal termination in his, plaintiff’s,
11 favor; (2) was brought without probable cause; and (3) was initiated with malice.”
12 *Bertero v. National General Corp.*, 13 Cal. 3d 43, 50 (1974).

13 Franz’s claims for malicious prosecution fail because Franz does not allege
14 that any prior legal action was commenced against her by Plaintiffs or was
15 ultimately terminated in her favor. In fact, no such events ever occurred.
16 Consequently, Franz has not satisfied, and cannot satisfy, any of the elements
17 required for a malicious prosecution claim, and her counterclaims for malicious
18 prosecution should be dismissed with prejudice.

19 **The Counterclaim Fails to Allege a Claim for Upcoding Fraud**

20 Franz alleges a claim for “upcoding fraud” in violation of California Penal
21 Code section 550 and the No Surprises Act codified at 28 U.S.C. § 9816, et al.
22 (Counterclaim, ¶¶ 45-48). This claim is baseless.

23 As an initial matter, Penal Code section 550 does not create a private right of
24 action. *See Agric. Ins. Co. v. Superior Ct.*, 70 Cal. App. 4th 385, 399–400 (1999)
25 (holding that there is no private cause of action for Penal Code section 550). In

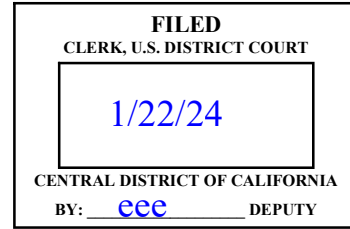
1 addition, Plaintiffs are unaware of any case in which a court has held that the No
2 Surprises Act created a private cause of action, and Franz has not alleged that
3 Congress intended to create such a right. *Corr. USA v. Dawe*, 504 F. Supp. 2d 924,
4 933 (E.D. Cal. 2007) (“As a general matter, where a statute does not explicitly
5 provide for a private action, the proponent must show that the legislature intended to
6 create such a right.”); *Cannon v. Univ. of Chicago*, 441 U.S. 677, 688 (1979)
7 (“[T]he fact that a federal statute has been violated and some person harmed does
8 not automatically give rise to a private cause of action in favor of that person.”).
9 Because there is no allegation or evidence that the No Surprises Act created a private
10 cause of action, Franz’s counterclaim for “upcoding fraud” is not a recognized civil
11 cause of action and should be dismissed with prejudice.

12 Even if Franz could articulate a recognized claim for “upcoding fraud,” it
13 would be barred by the parties’ settlement agreement in which Franz expressly
14 released Plaintiffs and their partners “from any and all manner of actions, causes of
15 actions, claims, and demands whatsoever, whether known or unknown, foreseen or
16 unforeseen, suspected or unsuspected, in law or in equity, and from all manner of
17 suits, claims of infringement, debts, sums of money, accounts, covenants, contracts,
18 controversies, agreements.” (Counterclaim Ex. A). Put simply, the exhibit trumps
19 Franz’s allegations, and her counterclaim for “upcoding fraud” should be dismissed
20 with prejudice. *See Thompson*, 300 F.3d at 754.

21 **The Counterclaim Fails to Allege a Claim for Balance Billing Fraud**

22 Franz’s counterclaim for “balance billing fraud” fails for the same reasons as
23 her counterclaim for “upcoding fraud,” namely: there is no indication that the No
24 Surprises Act allows for a private cause of action, and Franz released any potential
25 claim under the parties’ settlement agreement. Accordingly, this counterclaim

CARRIE L. STANFORD-FRANZ
1997 Shoemaker Ln.
Newbury Park, CA 91320
TEL (805) 728-0880
Plaintiff, *Pro Se*



UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA- WESTERN DIVISION

LOS ROBLES EMERGENCY	) CASE NO: 23-cv-09487-DSF-MAR
PHYSICIANS MEDICAL GROUP,	)
and RICHARD S. BENEDON,	) HON: D.S. FISCHER
	) HEARING DATE:
Plaintiffs/Counter-Defendants,	) February 5, 2024 @ 1:30pm
vs.	) COURTROOM: 7D
	) Roybal Building
CARRIE L. STANFORD-FRANZ,	) 350 W. First Street
	) Los Angeles, CA 90012
Defendant/Counterclaimant.	)
	) DEFENDANT/COUNTER-
	) CLAIMANT'S OPPOSITION TO
CARRIE L. STANFORD-FRANZ,	) MOTION TO DISMISS
Counterclaimant/Defendant,	)
	)
vs.	)
	)
LOS ROBLES EMERGENCY	)
PHYSICIANS MEDICAL GROUP,	)
and RICHARD S. BENEDON,	)
	)
Counter-Defendants/Plaintiffs	)
	)
	)
	)

1 Even after executing the mutual Release and being notified by the USPTO,
2 Counsel still filed this action knowing it was frivolous and lacked merit.

3 To make matters worse, Counsel intentionally redacted the corporate owner's
4 name from the screenshot of the website which he alleges infringes upon his
5 client's non-existent trademark. This clearly demonstrates Counsel knew Stanford-
6 Franz not the correct party and is trying to deceive the Court. *See* Complaint pg. 4
7 [Docket #1] compared to the actual webpage, a copy of which is attached hereto as
8 Exhibit D.

9 Further, Counsel has failed to even allege Stanford-Franz is the registrant of the
10 domain as required by the Cybersquatting statute.

11 **C. Upcoding Fraud:**

12 Stanford-Franz has clearly demonstrated upcoding fraud and negligent *per se*
13 violations of Penal Code §550. Stanford-Franz does not allege a private right of
14 action arises under Penal Code §550, but rather, §550 establishes the standard for
15 violations of upcoding fraud.

16 Likewise, Stanford-Franz has clearly demonstrated negligent *per se*
17 violations of the No Surprises Act and fraud by Plaintiffs' billing for surgical
18 services which were never rendered according to Plaintiffs' own medical report
19 and the release which states (*See* Exhibit C pg. 2 ¶1):

20 ***"The only treatment received was a prescription for***
21 ***pain medication. No surgical care was provided."***
22

23 **D. Negligence**

24 Counsel argues there needs to be a doctor-patient relationship to establish a
25 claim for negligence. Here, what Counsel conveniently leaves out is that Stanford-
26 Franz is the insured and her son was a minor at the time of the medical
27 malpractice.

28 //

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**UNITED STATES DISTRICT COURT
 CENTRAL DISTRICT OF CALIFORNIA – WESTERN DIVISION**

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Plaintiffs,

vs.

CARRIE L. STANFORD-FRANZ,

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CARRIE L. STANFORD-FRANZ,

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**LOS ROBLES EMERGENCY
 PHYSICIANS MEDICAL GROUP;
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Counterdefendants

) Case No.: 2:23-cv-09487-DSF-MAR
)
) **REPLY IN SUPPORT OF**
) **PLAINTIFFS AND**
) **COUNTERDEFENDANTS LOS**
) **ROBLES EMERGENCY**
) **PHYSICIANS MEDICAL GROUP**
) **AND RICHARD BENEDON’S**
) **MOTION TO DISMISS**
) **COUNTERCLAIMANT’S**
) **COUNTERCLAIMS PURSUANT**
) **TO FEDERAL RULE OF CIVIL**
) **PROCEDURE 12(b)(6)**

[Request for Judicial Notice filed
 concurrently herewith]

Date: February 5, 2024
 Time: 1:30 p.m.
 Courtroom: 7D

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Defendant and Counterclaimant Carrie L. Stanford-Franz’s (“Franz”) **late**¹ Opposition to Plaintiffs and Counterdefendants Los Robles Emergency Physicians Medical Group and Richard Benedon’s (collectively, “Plaintiffs”) Motion to Dismiss confirms that her Counterclaims are without merit and should be dismissed without leave to amend.

Franz spends most of her Opposition trying to argue against Plaintiffs’ trademark claims but fails to defend many of her counterclaims and flat out concedes that her other counterclaims are without merit. In particular:

- Franz does not attempt to defend her counterclaims for malicious prosecution, “balance billing fraud,” or unfair and deceptive competition, thereby conceding the issues;
- Franz admits that she does not allege a private right of action for “upcoming fraud” (because no such private right of action exists);
- Franz admits that she did not have a doctor-patient relationship that would allow her to assert a claim for medical malpractice;
- Franz ignores the plain language of the settlement and release agreement and therefore cannot maintain her claim for breach of contract.

In sum, Franz’s counterclaims are wholly frivolous and fail to state viable claims. They never should have been filed, and the Court should dismiss them with prejudice once and for all.

¹ Per Local Rule 7-9, Franz’s Opposition was due on or before January 16, 2024. She did not bother to serve her Opposition until the afternoon of January 22, 2024—**after** Plaintiffs filed and served their Notice of Non-Opposition (Dkt. 37).

1 **II. FRANZ HAS ABANDONED HER COUNTERCLAIMS FOR**
2 **MALICIOUS PROSECUTION, “BALANCE BILLING FRAUD,” AND**
3 **UNFAIR AND DECEPTIVE COMPETITION**

4 It is elementary that when a counterclaimant fails to address an argument
5 raised by a counterdefendant in a motion to dismiss, the counterclaimant has
6 “effectively abandoned” her counterclaims, and dismissal is appropriate. *See Walsh*
7 *v. Nev. Dep’t of Human Resources*, 471 F.3d 1033, 1037 (9th Cir. 2006) (where
8 opposition to motion to dismiss failed to address arguments in motion to dismiss, it
9 was “effectively abandoned” and could not be raised on appeal); *Toranto v. Jaffurs*,
10 297 F. Supp. 3d 1073, 1104 (S.D. Cal. 2018) (granting motion to dismiss on a claim
11 as the plaintiff abandoned the claim because he failed to address the issue in his
12 opposition); *In re TFT–LCD (Flat Panel) Antitrust Litig.*, 586 F. Supp. 2d 1109,
13 1131 (N.D. Cal. 2008) (dismissing a claim without leave to amend where the
14 plaintiff did not address the defendant’s arguments); *Silva v. U.S. Bancorp*, No.
15 5:10cv1854, 2011 WL 7096576, at *3 (C.D. Cal. Oct. 6, 2011) (“[T]he Court finds
16 that Plaintiff concedes his ... claim should be dismissed by failing to address
17 Defendants’ arguments in his Opposition.”); *Qureshi v. Countrywide Home Loans,*
18 *Inc.*, No. 09–4198, 2010 WL 841669, at *9 & n. 2 (N.D. Cal. Mar. 10, 2010) (citing
19 *Jenkins v. Cnty. of Riverside*, 398 F.3d 1093, 1095 n. 4 (9th Cir. 2005) (dismissing
20 claims as abandoned where the plaintiff did not oppose dismissal)).

21 Here, Franz has failed to address any of the arguments raised by Plaintiffs
22 related to her counterclaims for malicious prosecution, “balance billing fraud,” and
23 unfair and deceptive business practices. Consequently, the Court should dismiss
24 those counterclaims forthwith with prejudice.

1 **III. FRANZ ADMITS THERE IS NO PRIVATE CAUSE OF ACTION FOR**
2 **“UPCODING FRAUD”**

3 As explained in Plaintiffs’ Motion to Dismiss, “upcoding fraud” is not a
4 recognized civil cause of action and should be dismissed with prejudice. Mtn. 5:23-
5 6:11 (Dkt. 25-1).

6 Franz does not dispute Plaintiffs’ argument and instead alleges, “Stanford-
7 Franz does not allege a private right of action arises under Penal Code §550, but
8 rather, §550 establishes the standard for violations of upcoding fraud.” Opp. 5:13-
9 15. At best, Franz is confused. In order to bring a civil claim under Penal Code
10 section 550, there would, by definition, need to be a private right of action. Because
11 Franz has admitted that there is no such private right of action under Penal Code
12 section 550, her counterclaim for “upcoding fraud” should be dismissed with
13 prejudice.

14 Franz tries to rescue her counterclaim for “upcoding fraud” by claiming that
15 she has “demonstrated negligent per se violations of the No Surprises Act and fraud
16 by Plaintiffs’ billing for surgical services which were never rendered.” Opp. 5:16-18.
17 Notwithstanding Franz’s misuse of the terms “negligence per se” and “fraud,” she
18 has not alleged that the No Surprises Act allows for a private cause of action—
19 thereby conceding the argument.

20 Finally, Franz completely fails to address the fact (and Plaintiffs’ argument)
21 that she released all claims known and unknown against Plaintiffs in the parties’
22 settlement agreement. Accordingly, Franz’s counterclaim for “upcoding fraud” has
23 no legal merit and should be dismissed with prejudice.

IV. FRANZ ADMITS THAT SHE DOES NOT SATISFY THE ELEMENTS OF A CLAIM FOR MEDICAL MALPRACTICE

The first element of a claim for medical malpractice is the existence of a doctor-patient relationship. Mtn. 7:3-6 (citing *Quisenberry v. Compass Vision, Inc.*, 618 F. Supp. 2d 1223, 1229 (S.D. Cal. 2007); *Keene v. Wiggins*, 69 Cal. App. 3d 308 (1977)). Franz tries to argue around this basic requirement by claiming that she is entitled to bring a claim for medical malpractice because she “is the insured and her son was a minor at the time of the medical malpractice.” Opp. 5:26-27. Franz cites no legal authority for this breathtaking claim, because no such legal authority exists. Indeed, Franz’s argument is nonsensical on its face—why would an insured person have a claim for medical malpractice for something that did not happen to them? Are people without medical insurance barred from bringing claims for medical malpractice?

Even if Franz’s bizarre and baseless argument had merit (and to be clear, it does not), she once again ignores the fact that she released all such claims against Plaintiffs on behalf of herself and her son. Consequently, Franz’s counterclaim for negligence/medical malpractice is fatally flawed and should be dismissed with prejudice.

V. FRANZ’S COUNTERCLAIM FOR BREACH OF CONTRACT IS BASELESS

The settlement agreement between Franz and Plaintiffs is crystal clear: only Franz released claims against Plaintiffs. Plaintiffs did not release any claims against Franz. (Counterclaim Ex. A, ¶¶ 3, 4).

Franz first tries to get around the unambiguous language of the settlement agreement by quoting a portion of the agreement out of context that speaks of the

Exhibit 3

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Only the Westlaw citation is currently available.
United States District Court, D. New Jersey.

GPS OF NEW JERSEY M.D.,
P.C. A/S/O T.U., Petitioner,
v.
HORIZON BLUE CROSS &
BLUE SHIELD, Respondent.

Civ. No. 22-6614 (KM) (JBC)

Filed 09/08/2023

OPINION

Hon. Kevin McNulty United States District Judge

*1 Presently before the Court is the petition of GPS of New Jersey M.D., P.C. a/s/o T.U. (“GPS”) to vacate an arbitration award. (DE 1.)¹ Respondent Horizon Blue Cross & Blue Shield (“Horizon”) filed a cross-motion to confirm the arbitration award. (DE 12.) For the reasons set forth below, GPS’s motion to vacate the arbitration award is **DENIED** and Horizon’s motion to confirm the arbitration award is **GRANTED**. The Court’s reasoning, however, reflects the state of the law in the interregnum between the judicial invalidation of a certain interim rule by a decision filed on February 23, 2022, and the adoption of a new and different rule, effective October 25, 2022. *See* Section III.A, *infra*.

¹ Citations to the record will be abbreviated as follows:
“DE” = Docket entry number in this case
“Pet.” = GPS’s Petition to Vacate Arbitration Award (DE 1 & 1-5)
“Cross Mot.” = Horizon’s Brief in Opposition to GPS’s Petition to Vacate and in Support of Cross-Motion to Confirm Arbitration Award (DE 12-1)
“Opp.” = GPS’s Brief in Opposition to Horizon’s Cross-Motion to Confirm Arbitration Award (DE 18)
“Arb. Op.” = Decision of Island Peer Review Organization d/b/a iPro, issued August 18, 2022 (DE 18-4)

I. BACKGROUND

GPS is a medical practice in New Jersey. (Pet. p. 1 ¶ 1.) On February 5, 2022, GPS provided emergency plastic surgery services to patient T.U. (*Id.* p. 2 ¶ 1.) Following the procedure, GPS submitted a bill for the services to Horizon, T.U.’s insurance carrier. (*Id.* ¶ 2.) GPS is an out-of-network provider with respect to Horizon. (*Id.* ¶ 3.) In adjudicating the claim, Horizon remitted partial payment in the amount of \$430.84, with \$362.05 applied to T.U.’s deductible and \$46.36 paid to GPS. (*Id.*; *see* DE 1-5 p. 28; Cross Mot. p. 7.)

Because GPS is an out-of-network provider and the services were emergent or unanticipated in nature, Horizon’s partial payment was subject to the No Surprises Act (the “Act”), Pub. L. No. 116-260 (2020), codified at 42 U.S.C. § 300gg-111 *et seq.* (Pet. p. 2 ¶ 3.) Pursuant to the Act, discussed in more detail below, GPS and Horizon submitted to independent dispute resolution (“IDR”) arbitration before the IDR entity Island Peer Review Organization, d/b/a/ iPRO (herein, “iPRO”). (*Id.* ¶¶ 6–7); *see* 42 U.S.C. § 300gg-111(c) (1)(B).

GPS and Horizon submitted their proposed offers of payment and other information to iPRO for consideration. (Pet. ¶ 7; Cross Mot. p. 7.) GPS’s proposed reimbursement figure was approximately \$27,556, whereas Horizon’s figure was \$408.41. Under the applicable rules, the arbitrator was tasked, not with arriving at its own dollar figure, but with choosing between the parties’ positions. (*See* Pet. Ex. B; Cross Mot. Ex. 1.)

On August 18, 2022, iPRO issued a written payment determination. The substantive portion of that written determination states:

iPRO has reviewed your Independent Dispute Resolution (IDR) dispute with reference number DISP-03934 and determined:

The out-of-network payment amount of \$408.41 offered [by] Horizon BCBS under this dispute has been selected as the appropriate out-of-network rate for the following reason(s) –

*2 • After reviewing all correspondence from both parties, we have determined that Horizon BCBS provided more credible evidence to support their offer as fair and reasonable for the services in dispute.

(Arb. Op. p. 1.)

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GPS filed its petition to vacate the arbitration award on November 15, 2022. (DE 1.) On January 27, 2023, Horizon filed a cross-motion to confirm the arbitration award. (DE 12.) GPS filed its opposition on February 27, 2023 (DE 18), to which Horizon replied on March 13, 2023 (DE 19). GPS's petition to vacate and Horizon's cross-motion to confirm the arbitration award are fully briefed and ripe for decision.

II. NO SURPRISES ACT

A. Arbitration of reimbursement decisions under the Act

Congress enacted the No Surprises Act on December 27, 2020, to address “surprise medical bills.” *Texas Med. Ass’n v. United States Dep’t of Health & Hum. Servs.*, 587 F. Supp. 3d 528, 533 (E.D. Tex. 2022). “Generally, the Act limits the amount an insured patient will pay for emergency services furnished by an out-of-network provider and for certain non-emergency services furnished by an out-of-network provider at an in-network facility.” *Id.* (citing 42 U.S.C. §§ 300gg-111, 300gg-131, 300gg-132).

The Act also establishes a procedure for the payment of out-of-network providers by health insurers. Where, as here, the out-of-network provider is dissatisfied with the amount paid by the insurer and the parties are unable to resolve the dispute through negotiations, the parties may then proceed to IDR arbitration. 42 U.S.C. § 300gg-111(c)(1)(B).

The IDR entity must be certified through a process established by the Secretaries of Health and Human Services, Labor, and the Treasury, and must have “sufficient medical, legal, and other expertise” to make a determination under the Act. 42 U.S.C. § 300gg-111(c)(4)(A). The arbitration process is “baseball-style,” meaning that the provider and insurer each submit a final offer, and the IDR entity must select one of the two proposed amounts.² See *Texas Med. Ass’n*, 587 F. Supp. at 534; 42 U.S.C. §§ 300gg-111(c)(5)(A)–(B). When choosing between the two offers, the IDR entity must consider a number of factors:

(i) In general

In determining which offer is the payment to be applied pursuant to this paragraph, the certified IDR entity, with respect to the determination for a qualified IDR item or service shall consider--

(I) the qualifying payment amounts (as defined in subsection (a)(3)(E)) for the applicable year for items or services that are comparable to the qualified IDR item or service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR item or service; and

(II) subject to subparagraph (D), information on any circumstance described in clause (ii), such information as requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph (B)(ii).

(ii) Additional circumstances

For purposes of clause (i)(II), the circumstances described in this clause are, with respect to a qualified IDR item or service of a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer of group or individual health insurance coverage the following:

*3 (I) The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service (such as those endorsed by the consensus-based entity authorized in section 1395aaa of this title).

(II) The market share held by the nonparticipating provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided.

(III) The acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual.

(IV) The teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service.

(V) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

42 U.S.C. § 300gg-111(c)(5)(C). The IDR entity is also prohibited from considering usual and customary charges, the amount the provider would have billed for the item or service

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had the Act not applied, or the reimbursement rates for the item or service by a public payor. 42 U.S.C. § 300gg-111(c)(5)(D).

2 The reference, of course, is not to game of baseball *per se*, but to Major League Baseball salary arbitration. A form of “pendulum” arbitration, this procedure is designed to encourage reasonable compromise offers, *i.e.*, to push both parties from the extremes to the center for fear of losing all in the arbitration. *See, e.g.*, M.H. Bazerman and D. Kahneman, “How to Make the Other Side Play Fair,” Harvard Business Review (Sept. 2016), available online at <https://hbr.org/2016/09/how-to-make-the-other-side-play-fair>.

B. Standard of judicial review of arbitration award under the Act

Pursuant to 42 U.S.C. § 300gg-111(c)(5)(E), any determination of the IDR entity is binding on the parties and is only subject to judicial review under the circumstances described in Section 10(a) of the Federal Arbitration Act, 9 U.S.C. § 10. Section 10(a) of the FAA, incorporated by reference, provides four grounds upon which a district court may vacate the arbitration award:

- (1) where the award was procured by corruption, fraud, or undue means;
- (2) where there was evident partiality or corruption in the arbitrators, or either of them;
- (3) where the arbitrators were guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy; or of any other misbehavior by which the rights of any party have been prejudiced; or
- (4) where the arbitrators exceeded their powers, or so imperfectly executed them that a mutual, final, and definite award upon the subject matter submitted was not made.

9 U.S.C. § 10(a).

Most pertinent here are Sections 10(a)(3) and (4). Under Section 10(a)(3), “misconduct” is conduct that “so affects the rights of a party that it may be said that [the party] was deprived of a fair hearing.” *CPR Mgmt., S.A. v. Devon Park Bioventures, L.P.*, 19 F.4th 236, 245 (3d Cir. 2021) (quoting *Newark Stereotypers’ Union No. 18 v. Newark*

Morning Ledger Co., 397 F.2d 594, 599 (3d Cir. 1968)). A “fair hearing” is “one where the parties have notice and an opportunity to present evidence and arguments before an impartial arbitrator.” *Id.* To vacate an award under Section 10(a)(4), the plaintiff must show that the arbitrator “grant[ed] relief in a form that cannot be rationally derived from the parties’ agreement and submissions or issue[d] an award that is so completely irrational that it lacks support altogether.” *CPR Mgmt., S.A.*, 19 F.4th at 246 (quoting *Sutter v. Oxford Health Plans LLC*, 675 F.3d 215, 219–20 (3d Cir. 2012)) (cleaned up).

*4 That limited standard of review reflects a strong presumption in favor of enforcing arbitration awards. *Brentwood Med. Assocs. v. United Mine Workers of Am.*, 396 F.3d 237, 241 (3d Cir. 2005). “The United States Supreme Court has held that ‘the courts play only a limited role when asked to review the decision of an arbitrator.’ ” *Wilkes Barre Hosp. Co. v. Wyo. Valley Nurses Ass’n PASNAP*, 453 F. App’x 258, 260 (3d Cir. 2011) (quoting *United Paperworkers Int’l Union, AFL-CIO v. Misco, Inc.*, 484 U.S. 29, 36 (1987)). The moving party bears the burden of proving that the arbitration award at issue should be vacated, and the courts must “accord arbitration decisions exceptional deference.” *Handley v. Chase Bank USA NA*, 387 F. App’x 166, 168 (3d Cir. 2010). Further, an arbitration “award is presumed valid unless it is affirmatively shown to be otherwise.” *Brentwood Med. Assocs.*, 396 F.3d at 241.

III. MOTION TO VACATE ARBITRATION AWARD

GPS seeks to vacate the arbitration award under 9 U.S.C. §§ 10(a)(3) and (4) (Pet. p. 6.) According to GPS, the arbitrator refused to hear pertinent and material evidence, engaged in prejudicial misbehavior, and so imperfectly executed its powers that “a mutual, final, and definite award upon the subject matter submitted was not made.” (Opp. p. 6.) More specifically, GPS asserts that iPro’s one-sentence decision is a “net opinion” that fails to address the factors found in 42 U.S.C. § 300gg-111(c)(5)(C) and violates Federal Rule of Civil Procedure 52(a)(1).³ GPS also contends that it is prejudiced because the IDR entity’s written payment determination is unsigned. GPS further argues that the IDR entity improperly applied a presumption in favor of the “qualifying payment amount” or “QPA.”⁴ (Pet. ¶¶ 9–11 & pp. 6–8; Opp. pp. 5–13.) I address each argument in turn.

3 I dispose of this contention quickly. Federal Rule of Civil Procedure 52(a)(1) states: “In an action

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tried on the facts without a jury or with an advisory jury, *the court* must find the facts specially and state its conclusions of law separately. The findings and conclusions may be stated on the record after the close of the evidence or may appear in an opinion or a memorandum of decision filed by *the court*.” (emphasis added). Rule 52 governs findings of fact and conclusions of law by a district court to whom a matter has been submitted for a bench trial. GPS provides no support for its contention that the Rule applies to the IDR process under the No Surprises Act. I will not vacate the arbitration award on this basis.

- 4 The QPA generally means “the median of the contracted rates recognized by the plan or issuer ... under such plans or coverage, respectively, on January 31, 2019, for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished,” with increases based on the consumer price index. 42 U.S.C. §§ 300gg-111(a)(3)(E)(i)(I)–(II).

A. The vacated interim rule

Two of the pertinent issues raised by GPS concern the arbitrator's allegedly impermissible employment of a presumption in favor of the QPA, and the arbitrator's failure to file a reasoned decision describing the particular grounds for the award. Before considering GPS's substantive arguments, I must address an issue, addressed incompletely or not at all by the parties, concerning the applicability and effect of certain regulations promulgated pursuant to the No Surprises Act. As indicated above, I conclude that this case falls into an eight-month gap between the invalidation of an old regulation and the promulgation of a new one. For lack of a better option I will therefore default to generally applicable principles of arbitration law.

*5 On September 30, 2021, the relevant Departments issued what I will call the Interim Rule. [Requirements Related to Surprise Billing: Part II](#), 86 Fed. Reg. 55,980 (Oct. 7, 2021)).⁵ The Interim Rule in effect instructed the arbitrator to apply a presumption in favor of the QPA. In evaluating the two sides' offers “baseball-style,” the IDR arbitrator would be required to file a reasoned decision only if the arbitrator did not choose the offer closest to the QPA:

If the certified IDR entity does not choose the offer closest to the qualifying payment amount, the certified IDR entity's written decision must include an explanation of the credible information that the certified IDR entity determined demonstrated that the qualifying payment amount was materially different from the appropriate out-of-network rate, based on the considerations allowed under paragraph (c)(4)(iii)(B) through (D) of this section, with respect to the qualified IDR item or service.

45 C.F.R. § 149.510(c)(4)(vi)(B).

- 5 For simplicity, I will cite the HHS version of the Interim Rule that appeared at 45 C.F.R. § 149.510(c)(4)(vi)(B). As noted, responsibility is shared among the Secretaries of Health and Human Services, Labor, and the Treasury. Accordingly, substantively identical rules appeared at 29 C.F.R. § 2590.716-8(C)(4)(vi)(B) (Labor) and 26 C.F.R. § 54.9816-8T(c)(4)(vi)(B) (Treasury).

The Interim Rule had an effective date of October 7, 2021. It did not last long. By decision filed on February 23, 2022, the U.S. District Court for the Eastern District of Texas vacated the Interim Rule. *Texas Med. Ass'n v. United States Dep't of Health & Hum. Servs.*, 587 F. Supp. 3d 528, 549 (E.D. Tex. 2022), *appeal dismissed*, No. 22-40264, 2022 WL 15174345 (5th Cir. Oct. 24, 2022).

That ruling had two bases. First, the *Texas Medical Association* court reasoned that the Interim Rule conflicted with the text of the No Surprises Act because the Act “plainly requires arbitrators to consider all the specified information in determining which offer to select,” that it “nowhere states that the QPA is the ‘primary’ or ‘most important’ factor,” and that the Act does not impose a “rebuttable presumption” in favor of the QPA. *Id.* at 541. The court concluded that the rule impermissibly altered the requirements of the Act and must be vacated. *Id.* at 543. Second, the *Texas Medical Association* court concluded that, in the course of promulgating the Interim Rule, the Departments had failed to provide for notice

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and comment as required under the Administrative Procedure Act. *Id.* at 543–548. For this additional reason, the rule was flawed at the inception. Accordingly, the Eastern District of Texas held that the “the following provisions of the Rule are VACATED: ... 45 C.F.R. § 149.510(c)(4)(vi)(B); ... 26 C.F.R. § 54.9816-8T(c)(4)(vi)(B); ... and 29 C.F.R. § 2590.716-8(c)(4)(vi)(B).” 587 F. Supp. 3d at 549.

As noted, the date of that Eastern District of Texas decision was February 23, 2022. As of that date, the Interim Regulation became a nullity. On August 18, 2022, the iPro payment determination at issue in this case was filed.

In the meantime, however, the administrative agencies had been at work. In response to *Texas Medical Association*, the Departments issued a final rule on August 26, 2022, with an effective date of October 25, 2022, found at 45 C.F.R. § 149.510(c)(4)(vi)(B); 29 C.F.R. § 2590.716-8(c)(4)(vi)(B); and 26 C.F.R. § 54.9816-8(c)(4)(vi)(B)). See *Requirements Related to Surprise Billing*, 87 Fed. Reg. 52618-01 (Oct. 25, 2022). The new rule eschews the prior reliance on the QPA, and it requires a reasoned decision in *all* cases:

*6 The certified IDR entity's written decision must include an explanation of their determination, including what information the certified IDR entity determined demonstrated that the offer selected as the out-of-network rate is the offer that best represents the value of the qualified IDR item or service, including the weight given to the qualifying payment amount and any additional credible information under paragraphs (c)(4)(iii)(B) through (D) of this section. If the certified IDR entity relies on information described under paragraphs (c)(4)(iii)(B) through (D) of this section in selecting an offer, the written decision must include an explanation of why the certified IDR entity concluded that this information was not already reflected in the qualifying payment amount.

45 C.F.R. § 149.510(c)(4)(vi)(B).

That new rule, however, post-dated the decision at issue by eight days, and it expressly provides that its effective date falls still later, on October 25, 2022. It therefore does not apply to the present case. See *Sathanthrasa v. Att'y Gen. United States*, 968 F.3d 285, 293 n.5 (3d Cir. 2020) (quoting *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988)) (“[A]dministrative rules will not be construed to have retroactive effect unless their language requires this result.”).⁶

- 6 The parties have not raised any argument regarding the retroactive application of the final rule to iPro's decision.

B. Adequacy of the brief written payment determination

GPS essentially argues that there is nevertheless an implied requirement that the written payment determination be a reasoned decision. It contends that by failing to address in writing each of the required factors found in 42 U.S.C. § 300gg-111(c)(5)(C) in its written payment determination, iPro refused to hear relevant evidence in violation of Section 10(a)(3) of the FAA. GPS contends that it submitted to iPro a brief with exhibits presenting its position on the required factors, “additional credible information,” and its final offer. (Pet. Ex. B.) GPS claims that iPro cannot have considered its submissions because iPro's written payment determination consisted of only one sentence. (See Arb. Op.)

The arbitration decision is skimpy in the extreme, and as a reviewing court I would prefer to see more. I nevertheless find that the brevity of iPro's decision, alone, does not satisfy GPS's burden of proving that the arbitration award at issue must be vacated. Contrary to GPS's position that evidence was ignored, iPro's written payment determination states that it reviewed “all correspondence from both parties,” and found Horizon's evidence as to the fair and reasonable charge to be “more credible.” GPS fails to identify any indication that iPro should not be taken at its word. Rather, GPS takes the lack of a written explanation to be indicative of failure to give the matter due consideration.

As noted, iPro issued its written payment determination on August 18, 2022, after the Interim Rule was vacated, but before the Departments issued new regulations requiring a reasoned award. During that period there appears to have been no currently operative statute or rule requiring a reasoned written payment determination. The Court must therefore default to more general principles of arbitration law.

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It is a fundamental background principle of arbitration law that “arbitrators are under no obligation to give their reasons for an award.” *United Steelworkers of America v. Enterprise Wheel & Car Corp.*, 363 U.S. 593, 598 (1960). No further requirement of a reasoned award can be found in the No Surprises Act itself. The requirement that arbitrators be certified by the relevant government agencies was apparently deemed sufficient to ensure that they would apply the standards of 42 U.S.C. § 300gg-111(c), subject only to the safeguards of the FAA, 9 U.S.C. § 10(a), in cases of procedural failure or abuse.⁷

⁷ Indeed, there is every indication that Congress meant to prioritize efficiency in these arbitrations. The arbitrator is not called on, for example, to perform its own adjudication as to what a reasonable rate of reimbursement would be. The “baseball-style” procedure merely requires the arbitrator to pick which of the two proposals is the more persuasive.

*7 In search of some other legal requirement that the arbitrator furnish a reasoned decision, GPS cites “Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities” dated April 2022 (hereinafter the “Guidance,” submitted as Pet. Ex. C & Opp. Ex. A.) The first page of this document, however, states that it is not binding on the parties and does not have the force of law:

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

(Guidance p. 1.) In any event, the Guidance does not support GPS's argument that the IDR entity's one-sentence written payment determination is legally inadequate. The Guidance requires the IDR entity to *consider* the factors found in 42 U.S.C. § 300gg-111(c)(5)(C), not to discuss them expressly in the award: “In determining which offer to select, the certified IDR entity must *consider*: [t]he QPA(s) ... [and] [a]dditional credible information relating to the offers submitted by the

parties that relates to the circumstances[.]”⁸ (See Guidance pp. 18–22 (emphasis added).) The Guidance relied on by GPS does not require the IDR entity to provide a written decision detailing how it considered the additional credible information. The Guidance contemplates only that the IDR entity shall “explain its payment determination by submitting a written decision through the Federal IDR portal. Details on the form and manner for submitting the written decision will be provided in future guidance.” (Guidance p. 25.) No such “future guidance” is cited by the parties here.

⁸ The Guidance provides a table of “additional information” that follows the five factors found in 42 U.S.C. § 300gg-111(c)(5)(C). (Guidance p. 21.)

GPS cites to two cases (neither of them under the No Surprises Act) for the proposition that an arbitrator is legally required to provide more than a brief, conclusory decision: *Galloway Const., LLC v. Utilipath, LLC*, No. 13-cv-161, 2014 WL 3965118 (E.D. Tenn. Aug. 13, 2014), *on reconsideration*, No. 13-cv-161, 2014 WL 5361984 (E.D. Tenn. Oct. 21, 2014), and *Hagshama Manhattan 10 Gold, LLC v. Strulovitz*, No. 20-cv-04839, 2021 WL 1178028 (S.D.N.Y. Mar. 28, 2021), *appeal withdrawn* (Aug. 11, 2021). Both, however, rely on the particular provisions of the arbitration agreements there at issue.

In *Galloway*, the defendants sought to vacate an arbitration award because, among other reasons, the arbitration panel failed to render a “reasoned” award. 2014 WL 3965118 at *1. That arbitration award, they claimed, “fail[ed] to mention and analyze all of the defendants’ counterclaims and defenses, fail[ed] to make a connection between the facts at issue and the conclusions reached, and [was] otherwise unreasoned and perfunctory.” *Id.*

Galloway started from the general proposition that “arbitrators are under no obligation to give their reasons for an award.” *Id.* at *2 (citing *United Steelworkers of America*, 363 U.S. at 598).) That general principle, however, may be altered by agreement of the parties, and *Galloway* found that those parties’ arbitration agreement did indeed require a reasoned award: “[T]he arbitration agreement *required* the arbitration panel to analyze the issues, claims, counterclaims, and defenses of the parties and provide a ‘reasoned’ award on the merits of the parties’ claims and counterclaims.” *Id.* (emphasis added). So it was based on those parties’ private contractual agreement that the *Galloway* court vacated the arbitration panel's award for failure to state an express

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rationale. *Id.* at *2–*4. The *Galloway* court did not hold that an award without supporting reasons would have violated the Arbitration Act (or, of course, the No Surprises Act) as such.

*8 In *Hagshama*, the court was similarly tasked with deciding whether to confirm or vacate an arbitration award. 2021 WL 1178028 at *1. Like *Galloway*, the *Hagshama* Court recognized the fundamental proposition that an arbitrator generally does not need to provide a rationale for the award:

“The arbitrator’s rationale for an award need not be explained, and the award should be confirmed ‘if a ground for the arbitrator’s decision can be inferred from the facts of the case.’” *D.H. Blair [& Co. v. Gottdiener*, 462 F.3d 95, 110 (2d Cir. 2006)] (citing *Barbier v. Shearson Lehman Hutton, Inc.*, 948 F.2d 117, 121 (2d Cir. 1991)). “Only ‘a barely colorable justification for the outcome reached’ by the arbitrators is necessary to confirm the award.” *Id.* (citing *Landy Michaels Realty Corp. v. Local 32B-32J, Service Employees Int’l Union*, 954 F.2d 794, 797 (2d Cir. 1992)).

Hagshama, 2021 WL 1178028 at *4. However, as in *Galloway*, the parties’ arbitration agreement imposed the additional requirement that the arbitrator render a “reasoned decision” that “set[] forth the basic reasoning of the arbitral panel on the central issue or issues raised before it.” *Id.* at *5 (quoting *Leeward Constr. Co. v. Am. Univ. of Antigua - Coll. of Med.*, 826 F.3d 634, 636, 640 (2d Cir. 2016)).⁹

⁹ In any event, the *Hagshama* court ultimately determined that the arbitrator did sufficiently state its rationale and addressed the respondent’s arguments *Id.*

Unlike the dissatisfied parties in *Galloway* and *Hagshama*, GPS does not point to any private agreement requiring that the arbitrator issue a reasoned decision. There being no arbitration agreement or other contract imposing such a requirement, we are thrown back on the general principle that “arbitrators are under no obligation to give their reasons for an award.”

Here, iPro submitted a written decision that clearly set forth its payment determination. (See Pet. Ex. A.) GPS fails to cite to any provision of the Act or private contractual agreement that would render such a written decision, however brief, invalid *per se*. To invalidate an award, a party to the arbitration must show more—in particular, one of the essential flaws in the arbitration process that is set forth in 9 U.S.C. § 10(a).

GPS hypothesizes that the arbitrator could have reached a result contrary to GPS’s position only by refusing to “hear” GPS’s evidence. But the arbitrator here did not rule that GPS’s evidence was inadmissible, and it affirmatively represented that it had considered all of the submissions in arriving at its decision. While it is possible to disagree with the arbitrator’s award, there is no demonstration it could not have been reached based on the written record before the arbitrator.

I must therefore conclude that GPS has not met its burden of showing that the IDR entity refused to hear relevant evidence, in violation of Section 10(a)(3) of the FAA, or otherwise failed to fulfill any requirement that it render a reasoned decision.

C. Presumption in favor of the QPA

As noted above, *Texas Medical Association*, decided before the award was rendered here, vacated the then-applicable regulation, finding no basis in the statute for a presumption in favor of an award in the amount of the QPA. The QPA in this matter is \$408.41, the same amount awarded in arbitration. (See Arb. Op.; Pet. p. 8; DE 12-2.) GPS concludes that iPro must therefore have applied a presumption in favor of the QPA, to the prejudice of GPS. (Pet. p. 8.) According to GPS, the IDR entity’s conclusion that “Horizon BCBS provided more credible evidence to support their offer as fair and reasonable for the services in dispute ... appears to have presumed the QPA to be correct, and concluded that as [GPS] failed to present sufficient evidence or argument to rebut same, the QPA was, therefore, the appropriate out-of-network rate.” (Pet. p. 8.) GPS points to no other support for its contention that the IDR entity applied a presumption in favor of the QPA.

*9 The QPA generally means “the median of the contracted rates recognized by the plan or issuer ... under such plans or coverage, respectively, on January 31, 2019, for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished,” with increases based on the consumer price index. 42 U.S.C. §§ 300gg-111(a)(3)(E)(i)(I)–(II). “In other words, the QPA is typically the median rate the insurer would have paid for the service if provided by an in-network provider or facility.” *Texas Med. Ass’n*, 587 F. Supp. 3d at 535.

Texas Medical Association disallowed a presumption in favor of the QPA, but it did not of course prohibit consideration of the QPA or disallow any award that equaled or approximated

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the QPA. GPS's burden here would be to show that iPro applied a *presumption* in favor of the QPA, a different matter. GPS has not made such a showing. The Act goes no farther than to require the parties to submit their final offers to the IDR entity and to require the IDR entity to select one of those two amounts. *See* 42 U.S.C. §§ 300gg-111(c)(5)(A)–(B); *Texas Med. Ass'n*, 587 F. Supp. at 534. Here, Horizon offered \$408.41, which was equivalent to the QPA, and GPS sought approximately \$27,556. (Pet. Ex. B; Cross Mot. Ex. 1.) After reviewing all correspondence by the parties, iPro selected Horizon's offer as the more convincing—not necessarily “correct” in some larger sense, but more persuasive than GPS's offer. Now it is true that Horizon's offer was equivalent to the QPA, but that fact alone is not enough to show that the IDR entity applied some impermissible presumption in favor of the QPA. The IDR entity did not so much as mention the QPA or give any indication that it accepted Horizon's offer based on a presumption. What it said was that it had considered all the evidence, reviewed the two offers, and found Horizon's the more convincing of the two.

That “baseball-style” procedure may have failed in its purpose of pushing both sides to the middle. *See* p.4 n.2, *supra*. The offers remained very far apart, and the arbitrator's decision may have reflected no more than a rough determination that GPS's offer was, so to speak, farther out of the ballpark. There is no showing that the error claimed by GPS, assuming it would be an error, occurred.¹⁰ GPS has not met its burden of showing that the IDR entity's selection of Horizon's final offer was based on a presumption in favor of the QPA, or that it is judicially reversible on that basis.

¹⁰ I therefore note, but need not reach, the vexed issue of whether and to what extent an error of law requires reversal of an arbitration award. Returning to first principles, I find that GPS has not met its burden of showing an entitlement to reversal of the award on any of the four bases set forth under 9 U.S.C. § 10(a). The No Surprises Act is very clear that the determination of the IDR entity is subject to judicial review under the circumstances described in Section 10(a) of the Federal Arbitration Act, 9 U.S.C. § 10. 42 U.S.C. § 300gg-111(c)(5)(E). *See CPR Mgmt. S.A.*, 19 F.4th at 245 (listing these circumstances as the exclusive grounds to vacate an arbitration award). Courts may only consider these § 10(a) grounds, which do not include ordinary errors of law of the kind that might justify reversal on appeal. *See Sun Ship, Inc. v. Matson Navigation*

Co., 785 F.2d 59, 62 (3d Cir. 1986). Nothing like lawlessness, or “manifest disregard” of the law, to the extent that may be relevant, has been demonstrated here. *Bayside Construction LLC v. Smith*, No. 21-2716, 2022 WL 2593303, at *2 n.6 (3d Cir. July 8, 2022) (outside of No Surprises Act context, “assum[ing] without deciding” that an arbitration award could be vacated based on such “manifest disregard of the law”).

D. Certification of the IDR entity/Lack of signature

*10 GPS disputes the arbitration decision because it is “unsigned and gives no indication as to the qualifications or identity of the individual who authored it.” (Pet. ¶ 11; *see also* Pet. pp. 4–5.) As a result, GPS claims that it was prejudiced. As discussed, *supra*, the IDR entity must be certified through a process established by the Secretaries of Health and Human Services, Labor, and the Treasury, and must have “sufficient medical, legal, and other expertise” to make a determination under the Act. 42 U.S.C. § 300gg-111(c)(4)(A). GPS does not dispute iPro's qualification as a certified IDR entity under the Act. (*See* Pet. ¶ 6 (stating that iPro is an “approved IDR entity”).) Rather, GPS objects because the name of the individual at iPro who made the decision is unstated. GPS does not point to any requirement in the Act, the Guidance, or case law that the certified IDR decisionmaker be a disclosed natural person. I conclude that GPS has not met its burden of showing that it was prejudiced by the individual arbitrator's anonymity.

For all of the above reasons, the motion to vacate the arbitration award will be denied.

IV. CROSS-MOTION TO CONFIRM ABITRATION AWARD

Horizon filed a cross motion to confirm the arbitration award. Section 9 of the FAA states, in relevant part:

If the parties in their agreement have agreed that a judgment of the court shall be entered upon the award made pursuant to the arbitration, and shall specify the court, then at any time within one year after the award is made any party to the arbitration may apply to the court so specified for an order confirming the award, and thereupon

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the court must grant such an order unless the award is vacated, modified, or corrected as prescribed in sections 10 and 11 of this title. If no court is specified in the agreement of the parties, then such application may be made to the United States court in and for the district within which such award was made.

9 U.S.C. § 9. In short, unless the arbitration award is vacated pursuant to Section 10 or modified or corrected under Section 11 of the FAA, the award “must” be confirmed. In interpreting 9 U.S.C. § 9, “language that indicates the award will be final and binding implicitly permits Federal court intervention to compel compliance.” *New Jersey Bldg. Laborers’ Statewide Ben. Funds v. Newark Bd. of Educ.*, No. 12-cv-7665, 2013 WL 5180433, at *3 (D.N.J. Sept. 13, 2013) (quoting *Teamsters–Employer Local No. 945 Pension Fund v. Acme Sanitation Corp.*, 963 F. Supp. 340, 347 (D.N.J.1997)). In this case, the Act provides that any determination of the IDR entity is

binding on the parties and is only subject to judicial review under the circumstances described in Section 10(a) of the Federal Arbitration Act, 9 U.S.C. § 10. § 300gg-111(c)(5) (E). That language indicates the decision is to be “final and binding,” and gives the court the authority to confirm the award.

As set forth above, GPS has not met its burden of proving that the arbitration award at issue should be vacated. Accordingly, I will confirm the arbitration award.

V. CONCLUSION

For the reasons stated herein, GPS's motion to vacate the arbitration award is **DENIED** and Horizon's motion to confirm the arbitration award is **GRANTED**. A separate order will issue.

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General Information

Case Name	Guardian Flight LLC et al v. AETNA Life Insurance Company Inc et al
Court	U.S. District Court for the District of Connecticut
Date Filed	Thu Apr 11 00:00:00 EDT 2024
Judge(s)	Michael P. Shea
Federal Nature of Suit	Statutes: Other Statutory Actions [890]
Docket Number	3:24-cv-00680
Parties	AETNA Life Insurance Company Inc; Global Medical Response, Inc.; REACH Air Medical Services, LLC; CVS Pharmacy, Inc.; Cigna Health and Life Insurance Co.; Reach Air Medical Services LLC; Aetna Health Inc; Aetna Health and Life Insurance Company; CVS Health Corporation; Calstar Air Medical Services, LLC; Med-Trans Corporation; Air Evac EMS, Inc.; Guardian Flight LLC; AirMed International, LLC