The $3 Million Verdict in *Chatham Surgicore v. HCSC*, Insight from an Out-of-Network Unlicensed Facility Case

Douglas L. Prochnow
Partner
Edwards Wildman Palmer LLP
dprochnow@edwardswildman.com

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Chatham Surgicore v. Health Care Service Corp.:

Plaintiff: Chatham Surgicore ("Chatham") was an unlicensed out-of-network freestanding surgical facility on the south side of Chicago.

Defendant: Health Care Service Corporation d/b/a Blue Cross Blue Shield of Illinois ("BCBSIL") is one of the largest health insurance companies in the United States and the largest in Illinois.

- Chatham sued BCBSIL in state court seeking damages from BCBSIL for its failure to pay Chatham for millions of dollars in surgical facility fees for services it delivered to BCBSIL's insureds.
- Before each surgery Chatham called BCBSIL's provider telecommunications center to verify that coverage was available.
- BCBSIL always verified that coverage was available and disclosed no limitations on coverage.

Theory of the Case: Promissory Estoppel

To recover, a provider must allege and prove that:

1. The insurer made an unambiguous promise to the provider;
2. The provider was reasonable and justified in relying on the insurer's promise;
3. The provider's reliance was expected and foreseeable to the insurer; and
4. The provider was damaged.

- BCBSIL moved to dismiss Chatham's promissory estoppel claim arguing that it failed to state a legitimate cause of action.
- The trial court agreed and dismissed the case.
- Chatham appealed.

Appellate Decision

- *Chatham Surgicore, Ltd. v. Health Care Service Corporation*, 356 Ill.App.3d 795, 826 N.E.2d 970 (1st Dist. 2005)
- The appellate court reversed the trial court's decision to dismiss Chatham's promissory estoppel claim.
- The appellate court held Chatham had properly stated a cause of action for promissory estoppel.
- The appellate court sent the case back to the trial court for trial.

Element One: Unambiguous Promise

- The promise need not be express (e.g., "I promise to pay…") to satisfy the first element.
- A health insurer's statement that "coverage is available" = a promise.
- A health insurer's statement that "coverage is available" is also a *definite* and *complete promise* = an unambiguous promise.

Element Two: Reasonable Reliance

- The reason why a provider calls an insurer to verify coverage is important.
- A provider wants to determine whether it will be paid which means whether the patient has insurance coverage
- The provider calls the insurer because the provider does not have access to the individual patient's insurance policies.
- Consequently, it is reasonable for a provider to rely on the insurer's coverage promise in deciding whether to care for an insured patient.

Element Three: Provider's Reliance was Foreseeable to Insurer

- Again, the purpose behind the call to verify coverage is important.
- The insurer knows or should know when it says "*coverage is available*" it will induce the provider to treat the insured patient.
- It is thus foreseeable to the insurer that the provider will rely on its coverage promise and treat the insured patient.

Element Four: Damages

Based on the health insurer's coverage promise, the provider must show that it:

- Rendered the services to the patient; and
- It was damaged (i.e., did not get paid for the patient's treatment).

- **Important**: Each call that verifies coverage creates a contract between the insurer and out-of-network provider for payment of the services the provider delivers to the patient.

Defenses

- The trial was hotly contested.
- BCBSIL raised a number of defenses.

Defenses

- ERISA preempted Chatham's promissory estoppel claim.
  - The trial court ruled that ERISA did not apply because this was an implied-in-fact contract between Chatham and BCBSIL.

Defenses

- Chatham was not licensed.
  - The trial court granted summary judgment on this issue because BCBSIL never disclosed during the phone calls that Chatham had to be licensed.

Defenses

- BCBSIL's contracts with its patients prohibited the assignment of payments.
  - Chatham was not suing as the assignee of the patients.

Defenses

- Chatham failed to mitigate its damages by continuing to treat BCBSIL insureds after it knew it was not getting paid.
  - Rejected by the trial court because BCBSIL paid about ½ of Chatham's claims.
- Because Chatham knew it was not getting paid, BCBSIL also argued that this meant Chatham's reliance was not reasonable.
  - Again, this was rejected because BCBSIL paid about ½ of the claims.

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Defenses

- Because Chatham was not an in-network provider, BCBSIL did not have to pay it directly.
  - The trial court ruled that the implied-in-fact contract was between Chatham and BCBSIL. Therefore, BCSIL should have paid Chatham directly – as it sometimes did.

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Defenses

- BCBSIL denied at the beginning of each call that its verification of coverage was a guarantee of payment.
  - The trial court said that this disclaimer (assuming that it was given) did not defeat a promissory estoppel claim because it did not disprove any of the elements of promissory estoppel.

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Defenses

- Perhaps because of the nature of a promissory estoppel claim, BCBSIL never argued that these claims were not covered.
- Because Chatham was out-of-network, BCBSIL never argued that Chatham should be reimbursed at the levels found in the Schedule of Maximum Allowances.
- BCBSIL never argued that Chatham's billed charges were unreasonable.

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The Verdict

- The trial court ruled BCBSIL had failed to pay Chatham on more than 500 claims for surgical facility services.
- Trial court decided in favor of Chatham on every claim, even those claims where BCBSIL had sent a check to the patient.

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The Verdict

- Damage Award = nearly $3 Million.
- On those claims where BCBSIL quoted benefits the trial court awarded the quoted percentage of Chatham's billed charges.
- On those claims where BCBSIL refused to quote benefits, the court awarded 100% of Chatham's billed charges unless BCBSIL could document a lower percentage.

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Sanctions

- After the verdict the trial court considered Chatham's motion for sanctions because of BCBSIL's failure to produce various documents.
- The court granted the motion and awarded Chatham more than $150,000 in attorneys' fees.

Second Appeal

- Both sides appealed.
- Before any briefs had been filed BCBS decided not to settle but to tender.
- Besides the damage award of almost $3 Million BCBSIL paid pre-judgment interest = >$2.7 Million.
  - Chatham had argued that 215 ILCS 5/368a(c) entitled it to interest at 9% for claims paid > 30 days.
- BCBSIL also paid Chatham's court costs which were nominal.
- **Total Recovery** = **$5,875,181.52**

Coverage Verification: Best Practices for Providers

- **The provider should always tell the insurer's call representative**:
  1. Who will be *providing* the services (i.e., name of the provider);
  2. What services will be provided to the patient (e.g., surgical facility services);
  3. Who will be *receiving* the services (i.e., name of patient)
- **The provider should always make a written record of each coverage verification call**.

Additional Information a Provider Should Record:

- Patient name
- Date of call
- Phone number called
- Patient's group number
- Patient's identification number
- Anticipated date of service
- Name of person who placed the call for the provider
- Name of person who verified "coverage was available" for the insurer
- Effective date of patient's policy
- Percentage of benefits available.
- Deductible and amount of deductible that patient has met to date, if any.
- Out of pocket limit, if any.
- Lifetime max. (e.g., $1.5M)
- Any limitations on coverage
  1. Is pre-certification required?
  2. Is a second opinion required?
  3. Is a referral from a primary care doctor required?

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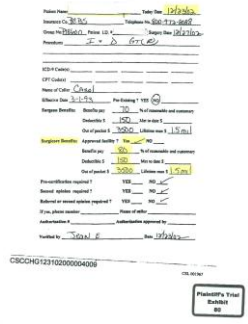
Sample Verification Worksheet



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Thanks

Douglas L. Prochnow
Partner
Edwards Wildman Palmer LLP
225 W. Wacker Drive, Suite 2800
Chicago, Illinois, 60606

(312) 201-2526 = Direct Dial

dprochnow@edwardswildman.com
www.edwardswildman.com/DProchnow

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