2016 IL App (1st) 141870-U

FIFTH DIVISION
June 24, 2016

No. 1-14-1870

IN THE APPELLATE COURT
OF ILLINOIS
FIRST JUDICIAL DISTRICT

AMBULATORY SURGICAL CARE FACILITY, LLC, MEDICOS PAIN & SURGICAL SPECIALISTS, S.C., and MARQUE MEDICOS 26th STREET, LLC,	)	Appeal from the Circuit Court of Cook County.
Plaintiffs-Appellees,	)	
v.	)	No. 12 L 2006
THE CHARTER OAK FIRE INSURANCE COMPANY and THE MARVEL GROUP, INC.,	)	Honorable Thomas Mulroy, Jr.,
Defendants-Appellants.	)	Judge Presiding.

JUSTICE BURKE delivered the judgment of the court.[*]
Presiding Justice Reyes and Justice Gordon concurred in the judgment.

ORDER

¶ 1 *Held*: The trial court's judgment is reversed where (1) the court did not err by finding that it had jurisdiction to decide the promissory estoppel claim but (2) the court erred by finding that plaintiff established all of the necessary elements of promissory estoppel.

¶ 2 Plaintiffs, Ambulatory Surgical Care Facility, LLC (Ambulatory); Medicos Pain & Surgical Specialists, S.C. (Medicos); and Marque Medicos 26th Street, LLC (26th Street) filed a

[*]This case was recently reassigned to Justice Burke.

promissory estoppel suit against defendants, the Charter Oaks Insurance Co. (Charter Oaks) and the Marvel Group, Inc. (Marvel), seeking to recover certain charges incurred during the performance of an outpatient surgery on one of Marvel's employees. The trial court found in favor of plaintiffs and awarded them $53,720.68.

¶ 3 Defendants appeal, arguing (1) the Illinois Workers' Compensation Commission (Commission) had exclusive jurisdiction over plaintiffs' promissory estoppel claim under the Workers' Compensation Act (Act) (820 ILCS 305/1 *et. al.* (West 2012)), (2) the trial court's award should be reversed because plaintiffs failed to establish their burden of proving all of the elements of promissory estoppel, and (3) the court's award should be reversed because the Ambulatory facility was unlicensed.

¶ 4 Because we agree that plaintiffs failed to establish all of the elements of promissory estoppel, we reverse the trial court's judgment.

¶ 5 I. BACKGROUND

¶ 6 Ambulatory, Medicos and 26th Street are affiliates in the same medicine practice. Ambulatory is the health care facility provider. Medicos and 26th Street are health care providers.

¶ 7 Travelers Indemnity Company (Travelers) is an insurance provider and its subsidiary, Charter Oaks, provides workers' compensation insurance. Charter Oaks provided workers' compensation insurance to Marvel.

¶ 8 Victor Leos was employed by Marvel. In June of 2009, Leos suffered a shoulder injury while on the job and sought compensation under the Act. Prior to performing a surgical procedure on Leos' shoulder, Medicos sought pre-approval from Travelers/Charter Oak.

Travelers/Charter Oak asked Dr. Cole[1] to conduct an independent medical exam of Leos. After he examined Leos, Dr. Cole approved the surgical procedure requested by plaintiffs.

¶ 9 Katharine Mestan, a nurse medical case manager for Travelers/Charter Oak, found that the requested procedure was medically necessary and appropriate based on Dr. Cole's examination of Leos. On behalf of Travelers/Charter Oak, Mestan sent a pre-approval letter to plaintiffs stating that the treatment of Leos had been reviewed and determined to be medically necessary. Further, the letter stated that Leos had been approved for the recommended surgery on his shoulder.[2]

¶ 10 Dr. Ellis Nam performed outpatient shoulder surgery on Leos at the Ambulatory facility. Ten days after the surgery, Travelers/Charter Oak received a bill from Ambulatory for facility charges totaling $84,392.64.[3] Ambulatory understood the Act's fee schedule authorized it to collect 76% of the bill based on the insurance reimbursement codes that were assigned for the procedures. Ambulatory's bill did not include any of Dr. Nam's services for the surgical procedures he performed, as these services were billed and paid for separately.

¶ 11 After receiving the bill, Travelers/Charter Oak's workers' compensation claim professional, Katharine Cromwell, reviewed the Leos file. Cromwell's duties included determining which benefits to pay or deny under the Act. She sent the Leos bill to Travelers/Charter Oaks' medical bill review team for review and re-pricing. The medical bill review team generated an Explanation of Reimbursement for the bill stating "provider is not licensed or provider's license has been revoked. Payment withheld."

[1] Dr. Cole's first name is unknown.
[2] This certification letter also contained the caveat," the certification for services is not a guarantee of payment."
[3] The charges included the following: $21,463.04 for rotator cuff repair-arthroscopy, $13,501.80 for debridement/arthroscopy, $13,501.80 for partial synovectomy, $13,501.80 for clavical resection-arthroscopy, $863.16 for anchor/screw, $98.00 for surgical supplies.

¶ 12 A demand letter for the unpaid Leos bill was sent on behalf of Ambulatory to Travelers/Charter Oak, stating that Ambulatory was an accredited facility. Ambulatory requested an appeal of the denial, citing an analysis of the Act's fee schedule and calculation that the total amount due was $34,270.85. Ambulatory stated that it was not required to be licensed in order to receive reimbursement for facility charges.

¶ 13 Thereafter, Travelers/Charter Oak reconsidered its earlier denial and paid Ambulatory $26,619.85. The reconsideration lists five services as billed by Ambulatory. There was no testimony as to why the reconsideration only listed five services when the original bill listed seven, nor was any evidence presented explaining the reason for the amount of the payment.

¶ 14 Plaintiffs filed a promissory estoppel suit in the trial court. During the same time period, Leos' workers' compensation suit against Marvel went to trial before an arbitrator of the Commission. Ambulatory, 26th Street, and Medicos were not participants to the arbitration. However, during the arbitration hearing before the Commission, Leos' attorney entered into evidence the pre-certification letter from Travelers/Charter Oak as well as a report describing how Ambulatory was entitled to 76% of its charges. The report indicated Ambulatory requested $37,518.57 from Travelers, which was the difference between the amount Ambulatory actually received and 76% of the bill charged pursuant to the Commission schedule. Ambulatory prepared a statement of the Ambulatory facility charges that remained due and owing after Travelers/Charter Oak's $26,619.16 payment. Ambulatory calculated $64,138.41 as the amount still due and owing. Leos' employer, Marvel, entered into evidence an analysis of the Commission fee schedule and calculated the total facility charges for the surgery as $22,689.16.

¶ 15 The arbitrator awarded $22,689.16 for the charges billed by Ambulatory. The arbitrator also found that Marvel's insurer overpaid the Ambulatory facility by nearly $4,000, having

already paid the facility $26,619.16. No review was taken before the Commission and no appeal was filed before the circuit court and the decision became final.

¶ 16 Following the arbitration decision, plaintiffs' bench trial on their promissory estoppel claim commenced. Four issues were presented to the trial court: (1) whether the Commission had exclusive jurisdiction over the claims presented; (2) whether plaintiffs were collaterally estopped from pursuing their claims as a result of the Commission's final decision; (3) whether plaintiffs met their burden of proving the elements of promissory estoppel; and (4) whether the Ambulatory facility was required to be licensed to recover its facility charges. In rebuttal, the trial court heard evidence that four days prior to trial, Travelers/Charter Oak pre-authorized a surgery at the Ambulatory facility.

¶ 17 The trial court found in favor of plaintiffs on all four issues. The court concluded that the workers' compensation aspect of plaintiffs' claim was collateral to plaintiffs' promissory estoppel action. Further, the court found that plaintiffs were not collaterally estopped because they were not a party to the arbitration between Leos and Marvel. The court also found that Travelers/Charter Oak made an unambiguous promise to the Ambulatory facility, upon which Ambulatory detrimentally relied. The court interpreted section 8.2 of the Act (820 ILCS 305/8.2 (West 2012)) and the portion of the Illinois Administrative Code (Code) relating to the Commission Medical Fee Schedule (50 Ill Adm. Code 7110.90) as allowing 76% of the actual charges submitted by Ambulatory. Finally, the court held that Ambulatory's failure to obtain a license was not fatal to plaintiffs' claim.

¶ 18 The court awarded plaintiffs $53,720.68, including $37,443.19 plus $16,277.49 in interest pursuant to the Act.

¶ 19 This appeal followed.

¶ 20 II. ANALYSIS

¶ 21 On appeal, defendants argue (1) the Commission had exclusive jurisdiction over plaintiffs' promissory estoppel claim under the Act, (2) the trial court's award should be reversed because plaintiffs failed to establish their burden of proving all of the elements of promissory estoppel, and (3) the court's award should be reversed because the Ambulatory facility was unlicensed.

¶ 22 For the following reasons, we find the trial court correctly found that it had jurisdiction to decide the promissory estoppel claim. However, we reverse the trial court's judgment because the court erred by finding plaintiff established all of the necessary elements of promissory estoppel.

¶ 23 A. The Trial Court Had Jurisdiction To Decide the Issue of Promissory Estoppel

¶ 24 This case requires us initially to address whether the Act allowed for plaintiffs to sue defendants in the trial court instead of through proceedings in the Commission. Because this is an issue calling for statutory interpretation, our review is *de novo*. *Kean v. Wal-Mart Stores, Inc.*, 235 Ill. 2d 351, 361 (2009).

¶ 25 Defendants initially claim that the Act precluded the trial court from resolving this "fee dispute." Specifically, defendants rely on section 18 of the Act, which states that “[a]ll questions arising under this Act, if not settled by agreement of the parties interested therein, shall, except as otherwise provided, be determined by the Commission.” 820 ILCS 305/18 (West 2012).

¶ 26 Plaintiffs were not parties to the workers' compensation arbitration. Further, the Illinois Supreme Court has found that section 18 of the Act does not deprive the trial court of concurrent jurisdiction. In *Employers Mutual Cos. v. Skilling*, 163 Ill. 2d 284, 285-86 (1994), the supreme court rejected the defendant's claim that the Industrial Commission had exclusive jurisdiction over a dispute relating to whether a workers' compensation carrier was required to provide

coverage or pay workers' compensation benefits under the terms of its insurance contract. The supreme court stated, "We rule that the jurisdiction is concurrent and that the jurisdiction of the circuit court is paramount." *Id.* at 286.

¶ 27 Illinois courts have original jurisdiction over all justiciable matters. Ill. Const.1970, art. VI, § 9. The legislature may vest exclusive original jurisdiction in an administrative agency. *Skilling*, 163 Ill. 2d at 287. However, a legislative enactment that divests the circuit courts of their original jurisdiction through a comprehensive statutory administrative scheme must do so explicitly. *People v. NL Industries*, 152 Ill.2d 82, 96-97 (1992). The Act's pronouncement that "[a]ll questions arising under this Act * * * shall * * * be determined by the Commission" is insufficient to divest the circuit courts of jurisdiction. *Skilling*, 163 Ill. 2d at 287 (quoting 820 ILCS 305/18 (West 1992)).

¶ 28 Further, the doctrine of primary jurisdiction did not require the trial court to decline resolution of this dispute in deference to the Commission, as "[i]t is the particular province of courts to resolve questions of law" like the one presented in this promissory estoppel case. *Id.* at 288-89. "Administrative agencies are given wide latitude in resolving factual issues but not in resolving matters of law." *Id.* at 289. The dispute presented before the trial court to determine whether Travelers/Charter Oak made an unambiguous promise to Ambulatory, which would enable plaintiffs to establish their promissory estoppel claim, is precisely the type of legal interpretation that a court, rather than the Commission is intended to address. The Commission's expertise would not be helpful in resolving whether plaintiffs had established their theory of promissory estoppel. Thus, the trial court had jurisdiction to hear plaintiffs' claim. See *Fredericks v. Liberty Mutual Ins. Co.*, 255 Ill. App. 3d 1029, 1034-35 (1994) (finding that the circuit court had jurisdiction over a breach of contract claim); see also *Moore v. Lafayette Life*

Ins. Co., 458 F.3d 416, 427 (6th Cir. 2006) ("[c]laims for breaches of fiduciary duty and promissory estoppel are not claims for denial of benefits and are therefore addressed in the first instance in the district court, requiring no deference to any administrator's action or decision").

¶ 29 The trial court found that jurisdiction was proper under section 8.2(f) of the Act, which reads as follows: "Nothing in this Act shall prohibit an employer or insurer from contracting with a health care provider or group of health care providers for reimbursement levels for benefits under this Act different from those provided in this Section." 820 ILCS 305/8.2(f) (West 2012).

¶ 30 Defendants claim that no contract existed and therefore this section cannot confer jurisdiction. However, in rebuttal, the trial court heard evidence that four days prior to trial, Travelers/Charter Oak pre-authorized a surgery at the Ambulatory facility. There is nothing in the Act that would prohibit a party from bringing a cause of action against a provider when the allegation is that the party was somehow guaranteed an additional payment, separate and apart from what the Commission would provide. Therefore, we are not persuaded by defendants' argument that only the Commission had the ability to resolve fee disputes and that any additional claims are forgone.

¶ 31 Defendants also posit that where the Commission has issued an award and deemed a service compensable, the provider is bound by the final award. In support of this proposition, defendants cite *Tiburzi Chiropractic v. Kline*, 2013 IL App (4th) 121113, a case defendants describe as being "particularly instructive."

¶ 32 In *Tiburzi*, the plaintiff treated the defendant for a work-related injury. *Id.* ¶ 4. According to the plaintiff, prior to treatment, the plaintiff explained to the defendant that the defendant would have to cover the cost of treatment himself if it was not covered by the workers' compensation insurance carrier, to which the defendant agreed. *Id.* ¶ 8. The plaintiff further

testified that the workers' compensation insurer paid out a portion of the plaintiff's billed charges. *Id.* The defendant refused payment of the balance and the plaintiff sued the defendant in small claims court for the balance. *Id.* ¶ 5. The trial court ordered the defendant to pay a specified amount for the treatment he received. *Id.* ¶ 9.

¶ 33 The appellate court ruled that the trial court erred in awarding the plaintiff a money judgment for compensable services in excess of the fee schedule set by the Commission. *Id.* ¶¶ 12-13. The court agreed with the defendant that the plaintiff's compensable services under the Act were not recoverable. *Id.* ¶ 11.

¶ 34 *Tiburzi* in no way deprived the trial court of jurisdiction. And in fact, *Tiburzi* reinforces the obvious conclusion, that whether a plaintiff can prevail on his claim does not determine whether the trial court has jurisdiction.

¶ 35 What plaintiffs have alleged here is that the insurer, Charter Oaks/Travelers, guaranteed their payment of the $84,000 and therefore the amount that the Commission awarded plaintiffs merely reduced the amount of money for which they had already been guaranteed payment. Therefore, the trial court correctly found it had jurisdiction. Parties have always been able to contract separately with insurers and providers to agree to take an amount smaller or greater than the amount the Commission awards them. There is nothing in the Act that precludes a party from seeking an additional remedy it believes it is owed. This action was then properly brought in the trial court.

¶ 36 B. The Trial Court Erred in Finding That Plaintiff Sufficiently Proved All the Elements of Promissory Estoppel

¶ 37 Although the trial court correctly found that it had jurisdiction, we agree with defendants that the court erred by finding plaintiffs established all of the elements required to recover on a promissory estoppel claim.

¶ 38 Promissory estoppel is an equitable doctrine under which plaintiffs had the burden of proving each of the following four elements: (1) defendants made an unambiguous promise to plaintiffs, (2) plaintiffs relied upon that unambiguous promise, (3) plaintiffs' reliance was expected and foreseeable by defendants, and (4) plaintiffs relied on the promise to their detriment. *Newton Tractor Sales, Inc. v. Kubota Tractor Corp.*, 233 Ill. 2d 46, 51 (2009).

¶ 39 Plaintiffs' complaint alleged that the pre-certification letter sent to Ambulatory by Travelers/Charter Oak was an unambiguous promise on behalf of Travelers/Charter Oak to pay Ambulatory's facility charges, thereby establishing a quasi-contract under a theory of promissory estoppel. Plaintiffs' entire case was based upon the pre-certification letter. Medicos sought pre-approval of the surgical procedure from Travelers/Charter Oak. In response, Travelers/Charter Oak asked Dr. Cole to conduct an independent medical examination of Leos. Dr. Cole did so and approved the requested surgical procedure. Katharine Mestan, a nurse medical case manager for Travelers, was assigned the Leos file to determine whether Travelers would pre-certify the surgery requested by Medicos. Mestan determined the surgery was medically necessary and appropriate based on Dr. Cole's examination of Leos and she approved the procedure.

¶ 40 Mestan authored the pre-certification letter to plaintiffs. She stated in the letter, "the treatment of Victor Leos has been reviewed and has been determined to be medically necessary." She further listed "approved" services. The letter also stated, "the certification for services is not a guarantee of payment." There is nothing in the letter detailing the specific amounts that would be paid, the percentage of billed rates that would be awarded, or any deductibles or policy limitations. The letter contains no information regarding specific monetary amounts for any of the approved procedures.

¶ 41 The trial court found that the letter made an unambiguous promise to pay for the services rendered to Leos and that plaintiffs established all the elements of promissory estoppel. The court applied the fee schedule in the Act to establish the amount that was due and owing to plaintiffs. The court awarded plaintiffs $53,720.68, including $37,443.19 plus $16,277.49 in interest pursuant to the Act.

¶ 42 At the outset, the parties dispute the appropriate standard of review to be applied to the trial court's finding that plaintiffs established all of the elements of promissory estoppel. Defendants argue we should apply a *de novo* standard because the facts are undisputed and the only question before us is the application of the facts to the law. See *General Motors Corp. v. Pappas*, 242 Ill. 2d 163, 172 (2011) (applying a *de novo* standard because the issues in the appeal concerned the application of law to undisputed facts). Plaintiffs, on the other hand, posit a manifest weight of the evidence standard applies because the existence of the elements of promissory estoppel are questions of fact (see *First National Bank of Cicero v. Sylvester*, 196 Ill. App. 3d 902, 911 (1990)) and the court's findings were made after a bench trial. See *Pickus Construction and Equipment v. American Overhead Door*, 326 Ill. App. 3d 518, 522 (2001) ("[a]s this appeal comes to us following a bench trial, we will not disturb the decision of the trial court unless it is against the manifest weight of the evidence."). However, we need not resolve the parties' dispute regarding the standard of review because we conclude that under either standard, the trial court's judgment must be reversed.

¶ 43 The trial court found that the pre-certification letter satisfied the element of an unambiguous promise to plaintiffs. However, a year after the trial court found in favor of plaintiffs on this issue, this court found that promissory estoppel could not be established by similar statements from an insurer to a provider in *Centro Medico Panamericano, Ltd. v.*

Laborers' Welfare Fund Of the Health and Welfare Department Of the Construction And General Laborers' District Council Of Chicago And Vicinity, 2015 IL App (1st) 141690.

¶ 44 In *Centro*, the plaintiff, a healthcare provider, placed a verification call to the defendant, an insurance company, before each medical procedure to verify whether the defendant would cover the procedure. *Id.* ¶ 3. During the verification calls, the plaintiff provided the defendant with the health provider's name, the patient's name, insurance information, and the procedure and services to be performed. *Id.* The defendant responded by confirming coverage and the amount of benefits available for each procedure, which was a percentage of the plaintiff's billed charges. *Id.* The defendant paid the plaintiff on each of the claims pursuant to the plan's "usual and customary charges" for out-of-network providers, including applicable deductibles or coinsurance, which was significantly less than the billed amount. *Id.* Upon payment, the defendant also provided an explanation of benefits for each claim and explained why payments were not paid in full. *Id.*

¶ 45 The plaintiff filed a promissory estoppel suit against the defendant, contending that it was entitled to approximately $98,000 more on its claims. *Id.* ¶ 4. The plaintiff argued that the defendant's service representatives orally promised that the defendant would pay a fixed percentage of whatever amount the plaintiff billed, no matter how high or excessive. *Id.*

¶ 46 This court found that the plaintiff failed to establish a *prima facie* case for promissory estoppel because the plaintiff failed to show the defendant made the plaintiff an unambiguous promise to the extent of insurance coverage. *Id.* ¶ 13. The *Centro* court noted the plaintiff failed to provide any evidence, such as testimony from any of its claims representatives or an actual transcript of the calls, suggesting that the defendant's representatives made an unambiguous oral promise to the plaintiffs. *Id.* "In fact," the *Centro* court reasoned, the "plaintiff's insurance

verification forms" showed "the parties discussed levels of benefits and limitations on coverage under the Plan, including deductibles and coinsurance." *Id.* The plaintiff's written records from three of the calls expressly referred to “usual and customary,” and one log specifically referred to the “Blue Cross Blue Shield” allowed amount. *Id.* Further, six of the defendant's records referenced this standard. *Id.*

¶ 47 *Centro* is binding precedent and requires this court to find that the trial court erred in its determination that plaintiffs had proven all of the elements of promissory estoppel. *In Centro*, the defendants provided significantly more information to the plaintiff than Travelers/Charter did in this case, such as the usual and customary allowance, the benefits and limitations under the policy, and the typical amount allowed by Blue Cross/Blue Shield. *Id.* ¶ 13. Even so, the *Centro* court concluded that the plaintiff could not and did not establish that the defendant made an unambiguous promise. *Id.* Thus, we cannot say that Travelers/Charter Oaks definitively made plaintiffs an unambiguous promise based on the record before us. Clearly then, under the facts of this case, plaintiffs failed to sustain their burden.

¶ 48 The appellate court in *Centro* also rejected the plaintiff's alternative contention that because the plaintiff subjectively believed its own charges established what was usual and customary, and the defendant's representatives failed to dispel that belief, an ambiguous promise was made to the plaintiff's detriment. *Id.* ¶¶ 14-15. Applying the *Centro* court's finding in this regard to the case at bar, it appears that plaintiffs' understanding of the pre-certification letter was that the insurer was agreeing to pay whatever the plaintiff charged. Yet, as the *Centro* court explained, "it is common for a benefit plan to establish its own usual and customary limit on allowable payments. It is, however, not common or expected that an insurer or benefit plan would consent to paying a provider based on the provider's unilaterally determined usual and

customary charge. Plaintiff has provided no compelling reason why insurance companies, as a standard industry practice, would agree to terms that so unilaterally favor medical institutions, to the detriment of the insurance companies." *Id.* ¶ 15. The *Centro* court noted that the "plaintiff's office manager admitted that usual and customary limitation may not have meant the same thing to both parties, and [the] plaintiff did nothing such as request written documentation from [the] defendant to clarify this misconception." *Id.* Further, the court reiterated, the plaintiff offered no evidence that an unambiguous promise was even made and failed to provide extrinsic evidence supporting its claim that the parties shared a common intent under contract law. *Id.* (citing *Demos v. National Bank of Greece,* 209 Ill. App. 3d 655, 661 (1991) (concluding that because the specification of the interest rate to be charged was a significant element of a contract to loan money and the "plaintiff expressly pleaded no allegations," nor could any be implied, "as to interest, duration, and terms of repayment," there was no error in dismissal of the lawsuit)).

¶ 49 Moreover, under the Act, it is the Industrial Commission that decides the fair and customary charges of medical bills incurred by the injured worker. See 820 ILCS 305/8(a) (West 2012). Here, they determined that amount to be $22,689.00. For plaintiffs to obtain more than that amount, they are required to show an agreement by defendant to pay an agreed amount over $22,689.00. In the case at bar, they failed to show any such agreement.

¶ 50 Accordingly, since plaintiffs failed to carry their burden of establishing a *prima facie* case for promissory estoppel, their claim must fail. Therefore, we reverse the trial court's judgment. Because we are reversing the court's judgment based on plaintiffs' failure to establish a *prima facie* claim of promissory estoppel, we find for defendants. We need not address defendants' additional arguments.

¶ 51 III. CONCLUSION

¶ 52 For the reasons stated, we reverse the trial court's judgment.

¶ 53 Reversed.