COURT OF APPEALS
DECISION
DATED AND FILED

February 26, 2002

Cornelia G. Clark
Clerk of Court of Appeals

Appeal No. 01-0064 **Cir. Ct. No. 99-CV-1155**

STATE OF WISCONSIN **IN COURT OF APPEALS**
DISTRICT III

KAREN E. SETUNSKY AND TODD M. SETUNSKY,

PLAINTIFFS-APPELLANTS,

V.

JOHN C. GALLAGHER, M.D., THE MEDICAL PROTECTIVE COMPANY, PATIENTS COMPENSATION FUND AND BLUE CROSS BLUE SHIELD OF ALABAMA,

DEFENDANTS,

CLAIM MANAGEMENT SERVICES, INC., ANSUL, INCORPORATED, GRINNELL CORPORATION MEDICAL AND DENTAL PLAN, TYCO LABORATORIES, INC., AND EMPLOYEE BENEFIT TRUST,

DEFENDANTS-RESPONDENTS.

APPEAL from a judgment of the circuit court for Brown County: SUE E. BISCHEL, Judge. *Affirmed*.

Before Cane, C.J., Hoover, P.J., and Peterson, J.

¶1 PER CURIAM. Karen and Todd Setunsky appeal a summary judgment dismissing their damages claim against Claim Management Services, Inc. ("CMS"), Ansul Incorporated, Grinnell Corporation Medical and Dental Plan, Tyco Laboratories, Inc. and Employee Benefit Trust (collectively "the managed care defendants"). The Setunskys argue that the trial court erred by concluding that their claim against the managed care defendants is preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 (ERISA). We reject their arguments and affirm the judgment.

BACKGROUND

¶2 The Setunskys seek to recover damages for injuries Karen allegedly suffered during a laparoscopic procedure. At the time of the surgery, Karen was participating in a self-funded employee benefit plan offered through her employer, Ansul, Inc., and maintained by Ansul's parent corporation, Tyco International, Ltd. The purpose of the plan was to reimburse its participants for medical care covered by the plan. Each participant was able to select his or her own physician. The plan did not dictate who its members should see nor did it contract with physicians to provide medical services.

¶3 Tyco contracted with CMS to serve as third-party administrator of the plan. As part of its administrative duties, CMS assumed responsibility for utilization review. In other words, its role with respect to the plan was to determine what medical care would be covered under the provisions of the plan. To that end, the contract required CMS to:

> (1) evaluate the medical necessity of the treatment program which is proposed for the hospital confinement; (2) authorize admission for a specified period of time based on [CMS]'s evaluation of medical necessity; (3) advise the person initiating the request of the determination made and maintain records of all such determinations; and (4) promptly review any appeals of determinations made.

¶4 The contract further provided that "[t]he determinations made by [CMS] … are intended solely for the purpose of determining benefits payable under the plan and are not intended as medical advice or recommendations."

¶5 In August 1996, Karen experienced abdominal and pelvic pain and sought treatment from her primary gynecologist. Because she was dissatisfied with the course of action recommended by her primary gynecologist, Karen sought the advice of Dr. John Gallagher. After examination, Gallagher recommended a total abdominal hysterectomy and bilateral salpingo-oophorectomy. Karen agreed to the surgery and her claim was submitted to CMS for precertification.

¶6 Denise Starr, a registered nurse and CMS employee, performed a utilization review of Karen's claim and determined that Gallagher had not provided adequate information to precertify the procedure as medically necessary under the plan. In particular, Gallagher could not determine the etiology of Karen's abdominal pain and could only provide a general diagnosis of her pain. Gallagher subsequently contacted CMS to discuss its refusal to precertify the procedure. Starr and Gallagher discussed several treatment options that might have been appropriate to establish a diagnosis, including a CAT scan, an ultrasound and diagnostic laparoscopy. Gallagher rejected the CAT scan and ultrasound recommendations as inappropriate. He concluded, however, that the

diagnostic laparoscopy was a viable alternative and could ultimately reveal that a hysterectomy was medically necessary under the terms of the plan.[1]

¶7 It is undisputed that Karen ultimately decided to proceed with the laparoscopic procedure in lieu of paying out-of-pocket for the hysterectomy. During the laparoscopic procedure, Karen suffered a bowel injury that resulted in peritonitis. During a subsequent surgery to repair the bowel injury, a hysterectomy was performed. Medical expenses for both the laparoscopy and subsequent hysterectomy were paid pursuant to the plan.

¶8 The Setunskys filed a medical malpractice suit against Gallagher. The Setunskys further alleged that Starr stepped outside of her role as a utilization reviewer and into the realm of medical care provider so that the managed care defendants also were liable for her injuries. The circuit court granted the managed care defendants' motions for summary judgment and this appeal followed.

ANALYSIS

¶9 Summary judgment is appropriate when there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. WIS. STAT. § 802.08(2). A summary judgment motion presents a question of law that we review independently. ***United Methodist Church v. Culver***, 2000 WI App 132, ¶25, 237 Wis. 2d 343, 614 N.W.2d 523. Despite our independent standard of review, we value a circuit court's ruling on the matter. ***Id.***

[1] The Setunskys argue that disputed issues of material fact arise with respect to whether it was Starr or Gallagher who suggested the diagnostic laparoscopy. Assuming facts in a light most favorable to the Setunskys, it was ultimately Karen who decided to proceed with the laparoscopic procedure in lieu of paying out-of-pocket for the hysterectomy. Thus, the Setunskys have failed to present an issue of "material" fact. *See* WIS. STAT. § 802.08(2).

¶10 The Setunskys argue that the circuit court erred by concluding that their claim against the managed care defendants is within the scope of the Employee Retirement Income Security Act of 1974, § 502, 29 U.S.C. § 1132, and therefore completely preempted. State law claims are displaced when the claims fall within an area of the law that Congress has completely preempted. ***Metropolitan Life Ins. Co. v. Taylor***, 481 U.S. 58, 63-64 (1987). In order to determine whether a claim is within the scope of § 502(a), we must examine whether: (1) the plaintiff is eligible to bring a claim under that section; (2) the plaintiff's claim falls within the scope of an ERISA provision that the plaintiff can enforce via § 502(a); and (3) the plaintiff's state law claim cannot be resolved without an interpretation of the contract governed by federal law. ***Jass v. Prudential Health Care Plan, Inc.***, 88 F.3d 1482, 1487 (7th Cir. 1996). [2]

¶11 Turning to the first factor, Karen concedes that because she was a participant in an ERISA plan, she was eligible to bring a claim under § 502(a). With respect to the second factor, the Setunskys argue that their claim against the managed care defendants does not fall within the scope of any civil enforcement provision of ERISA § 502(a). The Setunskys contend that § 502(a) applies to claims for benefits denied. Because benefits were never formally denied and were

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[2] The Employee Retirement Income Security Act of 1974, § 502(a), 29 U.S.C. § 1132(a) provides:

> A civil action may be brought
>
> (1) by a participant or beneficiary
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> ….
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

ultimately paid, the Setunskys argue that their claim is not for benefits due under the plan and therefore not cognizable under § 502(a). We are not persuaded.

¶12 The Setunskys claim that Karen was not injured because benefits were denied, but rather because CMS stepped outside of its role as utilization reviewer to direct her medical care. The seventh circuit has recognized, however, that although a utilization reviewer may exercise medical judgment in context of the administration of benefits, the reviewer's determination is nonetheless one of benefits. *See* ***Jass***, 88 F.3d at 1489.

¶13 Here, the Setunskys claim that Starr directed Gallagher to perform the laparoscopic procedure, thus affecting the quality of care Gallagher provided. In his deposition, however, Gallagher stated that he did not view any of his conversations with CMS as a way of saying "you have to do this or you have to do [that]." Rather, he contacted CMS to determine what would and would not be covered under the plan. Gallagher averred, however, that his "practice is not predicated on what an insurance company will or will not pay." We conclude that Starr's actions in refusing to precertify the hysterectomy and suggesting alternate treatment options were made in the context of the administration of benefits. Because the Setunskys' claim may fundamentally be characterized as challenging the process of a determination of benefits, it falls within the scope of ERISA § 502(a).

¶14 With respect to the third factor, we conclude that the Setunskys' state law claim cannot be resolved without reference to the terms of the employee benefit plan. The plan outlined the benefits available to its participants and further, defined CMS's role as third-party administrator.

¶15 Having considered all three factors, we conclude that the Setunskys' claim falls under the scope of ERISA § 502(a) and is therefore completely preempted.[3] Therefore, we affirm the summary judgment dismissing their damages claim against the managed care defendants.

By the Court.—Judgment affirmed.

This opinion will not be published. *See* WIS. STAT. RULE 809.23(1)(b)5.

[3] Because the circuit court concluded that the Setunskys' damages claim was preempted by ERISA § 502, 29 U.S.C. § 1132, it declined to address preemption pursuant to ERISA § 514. 29 U.S.C. § 1144. Likewise, because this court concludes that the Setunskys' claim was preempted by § 502, we need not address preemption under § 514. *See* ***Sweet v. Berge***, 113 Wis. 2d 61, 67, 334 N.W.2d 559 (Ct. App. 1983) (only dispositive issues need be addressed).