

PRECEDENTIAL

Filed October 15, 2003

UNITED STATES COURT OF APPEALS  
FOR THE THIRD CIRCUIT

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No. 02-3381

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JOSEPH V. DIFELICE, JR.,  
Appellant

v.

AETNA U.S. HEALTHCARE; MICHAEL PICARIELLO, M.D.;  
SARAH FOWLER; EAR NOSE & THROAT ASSOC. OF  
CHESTER COUNTY, INC.; CHESTER COUNTY HOSPITAL

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Appeal from the United States District Court  
for the Eastern District of Pennsylvania  
(D.C. Civil No. 02-cv-03641)  
District Judge: Honorable John P. Fullam

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Argued March 14, 2003

Before: BECKER, *Chief Judge*,\* RENDELL and  
AMBRO, *Circuit Judges*.

(Filed October 15, 2003)

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\* Judge Becker completed his term as Chief Judge on May 4, 2003.

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**OPINION OF THE COURT**

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RENDELL, *Circuit Judge*.

We are once again called upon to determine whether a lawsuit claiming medical negligence is completely preempted by the civil enforcement provision of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a). Joseph V. DiFelice, Jr., appeals the order of the United States District Court for the Eastern District of Pennsylvania dismissing his complaint against Aetna/U.S. Healthcare, Inc. ("Aetna") for negligent conduct in regard to his medical treatment for sleep apnea and upper airway obstruction. DiFelice filed suit in state court, alleging that Aetna's instruction to his treating physician that a specially designed tracheostomy tube was "medically unnecessary" and Aetna's insistence that he be discharged from the hospital before his attending physician deemed it appropriate amounted to negligent conduct under state law. Aetna removed the case to federal court on the basis of ERISA preemption and then moved to dismiss the claim. The District Court, relying on our decision in *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001), held that the claim was completely preempted and dismissed it in its entirety. For the reasons that follow, we will affirm in part and reverse in part.

I.

DiFelice participates in an ERISA-governed employee welfare benefit plan that is administered by Aetna, a health maintenance organization ("HMO"). Under the terms of this plan, DiFelice is entitled to certain "Covered Benefits." Unless there is a specific provision for a particular type of treatment, a benefit is only covered if, in the determination of Aetna, it is "Medically Necessary." "Medically Necessary" is a defined term, meaning the service or supply must be "care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply;" must be "related to diagnosis of an existing illness or injury;" may

“include only those services and supplies that cannot be safely and satisfactorily provided at home;” and, “as to diagnosis, care and treatment[, must] be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply.”

In March 2001, DiFelice was diagnosed with “sleep apnea/upper airway obstruction,” for which he required a tracheostomy tube.<sup>1</sup> His doctor, Dr. Michael Picariello, surgically inserted a tracheostomy tube to eliminate the obstruction, but that tube continually came out. Dr. Picariello then placed an order for a specially designed tube. However, Aetna instructed Dr. Picariello that the special tube was “medically unnecessary.” Instead of ordering the special tube, the doctor then inserted a different tube, which caused DiFelice severe pain and resulted in an infection. DiFelice was later admitted to Chester County Hospital for treatment, but, the complaint avers, was thereafter discharged “at Aetna’s insistence.”<sup>2</sup>

DiFelice filed a five-count complaint in the Philadelphia Court of Common Pleas against Aetna, his treating physicians, and the hospital. In Count I, he alleged that Aetna negligently interfered with his medical care “by instructing Dr. Picariello that the specially designed tracheostomy tube he deemed necessary was medically unnecessary for [DiFelice] and improperly interfering with Dr. Picariello’s medical decision concerning the tracheostomy tube and insisting on [DiFelice’s] discharge

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1. Our recitation of the facts is derived from DiFelice’s complaint.

2. DiFelice objects to our consideration of the terms of the Plan in determining whether his complaint should be dismissed because he does not reference the Plan in his complaint, and Aetna did not argue below that the Plan provisions were dispositive. However, in ruling on a motion to dismiss, we may consider an extrinsic document that is “integral” to the complaint. See *In re Burlington Coat Factory Sec. Litig.*, 114 F.3d 1410, 1426 (3d Cir. 1997). Here, DiFelice’s reference to “medical necessity” is clearly derived from the terms of the Plan. Furthermore, even if Aetna did not explicitly argue that the Plan provisions controlled the decision in this case, Aetna attached the Plan as an exhibit to its brief and motion before the District Court. DiFelice was certainly on notice that the Plan terms were integral to Aetna’s argument.

from the [hospital] . . . before his attending physician was planning on discharging [him]." The other counts involved claims against parties other than Aetna. Aetna removed the case to the District Court on the grounds that the claim against it was completely preempted under ERISA and then moved to dismiss. DiFelice opposed the motion to dismiss and moved to remand to state court.

The District Court denied DiFelice's motion to remand and granted Aetna's motion to dismiss as to Count I, and granted the motion to remand on the remaining counts against the other parties. The Court held that the disposition of Count I was "squarely controlled by the Third Circuit's decision in *Pryzbowski*," in which we held that a claim challenging the "administration of or eligibility for benefits" was completely preempted by section 502(a)(1)(B) of ERISA. *Pryzbowski*, 245 F.3d at 273. The Court reasoned that the claim against Aetna was completely preempted because DiFelice was challenging Aetna's decision that he was not entitled to the special tube under the Plan, which was entirely a matter of administration, and because Aetna was not actually involved in providing any medical services to DiFelice. DiFelice appeals the District Court's order dismissing Count I.

## II.

We have jurisdiction over the District Court's final order pursuant to 28 U.S.C. §1291, and review the Court's exercise of jurisdiction and order of dismissal de novo. *Pryzbowski*, 245 F.3d at 268. Aetna bears the burden of proving the federal jurisdiction it seeks. *Spectacor Mgt. Group v. Brown*, 131 F.3d 120, 127 (3d Cir. 1997). In reviewing the complaint, we must accept as true all of DiFelice's factual allegations and draw all reasonable inferences therefrom. *Langford v. City of Atlantic City*, 235 F.3d 845, 847 (3d Cir. 2000).

DiFelice challenges the District Court's removal jurisdiction over Count I of his complaint and asks us to remand to state court. He argues that his negligence action against Aetna is entirely a matter of state law and provides no basis for removal. Aetna counters that DiFelice's

negligence action is in fact nothing more than an action to recover benefits due under his plan, and as such is completely preempted by the civil enforcement provision of ERISA, section 502(a).

#### **A. Framework**

Under the “well-pleaded complaint” rule, federal question jurisdiction only exists where an issue of federal law appears on the face of the complaint. *Franchise Tax Bd. of Cal. v. Constr. Laborers Vacation Trust for S. Cal.*, 463 U.S. 1, 24 (1983). However, there is an exception to this rule: when a purportedly state-law claim “comes within the scope of [an exclusively] federal cause of action,” it “necessarily ‘arises under’ federal law,” and is completely preempted. *Id.*; see also *Beneficial Nat’l Bank v. Anderson*, 123 S. Ct. 2058, 2062 (2003) (explaining the preemptive effect of ERISA). The question before us is therefore whether DiFelice’s claims of state law negligence on the part of Aetna fall within the scope of the federal causes of action provided in section 502(a) of ERISA, that is, whether the claims could have been brought under that section. If so, then the existence of the federal claim would provide the basis for federal question jurisdiction but at the same time would require dismissal based on complete preemption.

We have had numerous occasions to consider the question of whether a plaintiff’s claim against an HMO is covered by section 502(a) and is therefore completely preempted. See, e.g., *Pryzbowski*, 245 F.3d at 273-75; *Lazorko v. Pa. Hosp.*, 237 F.3d 242, 250 (3d Cir. 2000); *In re U.S. Healthcare, Inc.*, 193 F.3d 151, 162-63 (3d Cir. 1999); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 358 (3d Cir. 1995). Determining whether a claim could have been brought under ERISA has proven to be anything but an exact science. In fact, as my colleagues’ concurring opinions point out all too well, the exercise seems to have taken on a life of its own, and not a very satisfying or productive life at that. In any event, the statute and our case law chart the path we must follow.

Section 502(a) allows for civil actions to be brought “by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan.” 29 U.S.C. § 1132(a)(1)(B). The

line between an action to recover benefits, which challenges an administrative decision regarding whether a certain benefit is covered under an ERISA plan, and an action alleging negligence or malpractice, which challenges the medical treatment actually provided to a patient, is a blurry one. We have been continually refining the precise test we use in evaluating such claims.

Most recently, in *Pryzbowski*, we synthesized the discussions contained in our previous opinions and adopted preferable new terminology. We explained that in the past we had attempted to distinguish between claims directed at the *quality* of benefits received — that is, as to the treatment — which would not fall within section 502(a), and claims that the plans erroneously withheld a *quantum* of benefits due — focusing on the administration of the plan — which would be completely preempted. *Pryzbowski*, 245 F.3d at 272. Following this “quality-quantity” rubric, we had held that an allegation that an HMO had failed to exercise reasonable care in providing medical treatment was not preempted, *Dukes*, 57 F.3d at 358; an allegation that an HMO’s policy of discharging newborns within 24 hours after their delivery was essentially a medical determination and was not preempted, *In re U.S. Healthcare*, 193 F.3d at 163; and an allegation that an HMO’s financial disincentives discouraged medical providers from hospitalizing a mentally ill woman was a “quality of care” claim because it occurred in the course of a treatment decision, and was therefore not preempted. *Lazorko*, 237 F.3d at 250.

However, in *Pryzbowski*, we found the “quality-quantity” distinction unclear, and suggested that more helpful terminology was utilized by the Supreme Court in *Pegram v. Herdrich*, 530 U.S. 211 (2000). Although we recognized that *Pegram* “concerned fiduciary acts under ERISA and not preemption,” we found useful “the distinction made there between *eligibility decisions*, which turn on the plan’s coverage of a particular condition or medical procedure for its treatment,” and “*treatment decisions*, which are choices in diagnosing and treating a patient’s condition,” and determined that the distinction was “equally applicable for complete preemption analysis.” *Pryzbowski*, 245 F.3d at

273 (quoting *Pegram*, 530 U.S. at 228) (emphasis added and internal quotations omitted). We then explained,

Regardless of the language used, the ultimate distinction to make for purposes of complete preemption is whether the claim challenges the administration of or eligibility for benefits, which falls within the scope of § 502(a) and is completely preempted, or the quality of the medical treatment performed, which may be the subject of a state action.

*Id.*

Using this nomenclature, it was evident to us in *Pryzbowski* that “a claim alleging that a physician knowingly delayed in performing urgent surgery . . . would relate to the quality of care,” while on the other hand, “a claim alleging that an HMO declined to approve certain requested medical services or treatment on the ground that they were not covered under the plan would manifestly be one regarding the proper administration of benefits.” *Id.* (citing *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1488-89 (7th Cir. 1996)). However, we were presented there with claims that fell somewhere in between: that an HMO had negligently delayed approval of an out-of-network specialist, and that it had failed to supervise properly its employees to make “thoughtful and reasonable decisions as to healthcare.” *Id.* at 274. Were those claims based on a treatment decision or on a determination as to eligibility for a benefit? We explained that “[i]n analyzing whether a claim falling between the[] two poles is completely preempted, it is necessary to refer to § 502(a).” *Id.* at 273. Paring the issue down to its essence, we stated that the relevant question must be whether the claim “could have been the subject of a civil enforcement action under § 502(a).” *Id.* If it could have, then it was a plan benefit claim, and Congress has clearly expressed its intent that the claim be preempted by ERISA. *Id.* (citing *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 66 (1987)).

Because the claims in *Pryzbowski* fell between the two poles, we took extra care to examine the complaint for “artful pleading,” to ensure that *Pryzbowski* was not disguising an eligibility claim that could have been brought

under ERISA as a state law negligence claim. We explained that, although the claim might be “ostensibly directed at the provision of medical treatment,” we needed to “look beyond the face of the complaint to determine whether [Pryzbowski had] artfully pleaded his suit so as to couch a federal claim in terms of state law.” *Id.* at 274 (quoting *Jass*, 88 F.3d at 1488); see also *Franchise Tax Bd.*, 463 U.S. at 22 (“[A] plaintiff may not defeat removal [to federal court] by omitting to plead necessary federal questions in a complaint.”). The ultimate question was whether, when the basis for the claim was properly understood, the claim fell under ERISA.

After carefully examining Pryzbowski’s complaint for the true bases of his claims, we held that his claims were completely preempted. First, regarding the delayed approval, we concluded that underlying the HMO’s allegedly negligent activities was a *policy* decision regarding payment to and approval of out-of-network specialists, a decision that fell “within the realm of the administration of benefits.” *Pryzbowski*, 245 F.3d at 273. We explained that this claim could have been brought under ERISA because “[h]ad Pryzbowski sought to accelerate [the HMO]’s approval of the use of out-of-network providers, she could have sought an injunction under § 502(a) to enforce the benefits to which she was entitled under the plan.” *Id.* at 273-74. Further, her claim that the HMO had “failed to properly hire, train, and supervise its employees to make thoughtful and reasonable decisions as to healthcare” was also preempted because, reading behind the artful “medical negligence” pleading, the complaint did not allege that the HMO or its employees had actually engaged in any medical treatment. *Id.* at 274. Because the HMO’s only role was in administering Pryzbowski’s benefits, it could not possibly have been negligent in providing treatment. *Id.* Unlike the situation in which an HMO fills dual roles as an administrator of benefits *and* a provider of services, and might therefore actually engage in medical treatment, the HMO there was acting *solely* as an administrator. *Id.*

*Pryzbowski* thus instructs us to determine whether a claim is preempted under section 502(a) by first examining whether the claim falls at either of the two poles, entirely

treatment or entirely administrative. If based solely on a medical treatment decision, then the claim is not preempted. If based on an HMO administrator's eligibility decision, then the claim is preempted. In the more difficult situation in which the claim falls somewhere in between, we must scrutinize the complaint for "artful pleading," and then refer to section 502(a) itself and determine whether the actual alleged wrongdoing underlying the cause of action could have formed the basis of a suit under that section.

As discussed more fully below, when we apply the *Pryzbowski* framework to the complaint before us, we conclude that DiFelice's claim that Aetna "interfered with" his medical treatment by declaring the special tube "medically unnecessary" is preempted by ERISA because it could have been brought as an action under section 502(a). However, because it appears that DiFelice's claim that he was discharged "at the insistence of Aetna" does not rest on any discharge policy set forth in the Plan, or any agreed benefit, it would not be encompassed within the relief available under section 502(a) and is therefore not completely preempted.

#### **B. The Tracheostomy Tube**

We will first examine DiFelice's claim that Aetna interfered with Dr. Picariello's medical decision regarding the special tube. Under *Pryzbowski*, the first question is whether Aetna's "medical necessity" determination is clearly either a medical treatment decision or an eligibility decision. DiFelice has couched this claim in terms of Aetna's negligent interference with his care, which seems to imply that Aetna itself engaged in medical treatment. However, DiFelice's complaint does not include any allegation that Dr. Picariello was an agent of Aetna, that Aetna did not exercise reasonable care in monitoring Dr. Picariello's care, or that Aetna itself provided medical treatment; rather, his claim rests on Aetna's "instruction" to Dr. Picariello "that the specially designed tracheostomy tube he deemed necessary was medically unnecessary," a direct reference to the "medical necessity" determination called for in the Plan. Looking behind DiFelice's use of language sounding in negligence, he is alleging that Aetna

wrongfully denied him coverage for the special tube. Thus, the complaint has aspects of treatment and coverage. That is, in making its determination, Aetna necessarily had to exercise some medical judgment, i.e., it had to determine whether the special tube was “as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, . . . [was] related to diagnosis of an existing illness or injury, . . . [and was] no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply.” However, here there is no allegation that Aetna actually provided the medical care, and Aetna’s use of medical judgment could only have led to an eligibility, not a treatment, decision.

Because the decision here was in some sense both a medical treatment and an eligibility decision, thus falling between the two poles discussed in *Pryzbowski*, we must refer to section 502(a) and determine whether DiFelice’s claim regarding the tube could have been the subject of a civil enforcement action under ERISA. *Pryzbowski*, 245 F.3d at 273. Clearly, it could have been. DiFelice could have challenged Aetna’s “medical necessity” determination by filing a claim under 502(a)(1)(B) “to recover benefits due to him under the terms of his plan,” and arguing that the special tube was in fact “medically necessary,” and was therefore a “covered benefit.” He could have requested an injunction forcing Aetna to pay for the special tube, or alternatively, paid for the tube himself and then later filed an action for reimbursement. Numerous ERISA participants have in fact brought such actions challenging their HMO’s “medical necessity” determinations and seeking to recover benefits they alleged were due under their plans. See, e.g., *Mario v. P&C Food Mkts., Inc.*, 313 F.3d 758, 762-63 (2d Cir. 2002) (reviewing claim under section 502(a) challenging HMO’s determination that sex change operation was not “medically necessary”); *Fritcher v. Health Care Serv. Corp.*, 301 F.3d 811, 814-15 (7th Cir. 2002) (reviewing claim under section 502(a) challenging HMO’s determination that custodial care was not “medically necessary”); *Kopicki v. Fitzgerald Auto. Family Employee Benefits Plan*, 121 F. Supp. 2d 467, 480 (D. Md. 2000) (granting preliminary