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"Discovery in the Realm of Doctor's Liens and LOPs"

I. Recoverable Medical Damages in Personal Injury Cases

A. Making The Injured Party Whole

The fundamental purpose of compensatory damages is to make a plaintiff whole again.[1] Compensatory damages are designed to provide a plaintiff with the monetary amount necessary to restore them to their status quo before the tort occurred. Put another way, compensatory damages provide fair and just compensation, equal to the loss or injury sustained from the wrongful act, and nothing more.[2]

In the context of personal injury suits, compensatory damages include past and future medical expenses. It is the plaintiff's burden to prove such expenses. For example, the California civil jury instruction on recoverable medical expenses reads,

> To recover damages for past medical expenses, a plaintiff must prove the *reasonable cost* of *reasonably necessary* medical care that he or she has received. To recover damages for future medical expenses, a plaintiff must prove the *reasonable cost* of *reasonably necessary* medical care that he or she is reasonably certain to need in the future.[3]

Florida's instruction is similar. The plaintiff must prove "the *reasonable* value or expense of medical care and treatment *necessarily or reasonably obtained* by claimant in the past or to be so obtained in the future."[4]

An inquiry into the reasonable value of medical expenses is not limited to the amounts billed. This is a key concept in understanding and defending cases with inflated

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[1] PROSSER AND KEETON ON THE LAW OF TORTS §§ 1, 4 (W. Page Keeton, et al. eds., 5th ed. 1984).
[2] *Scalp & Blade v. Advest, Inc.*, 765 N.Y.S.2d 92, 97 (N.Y. App. Div. 2003).
[3] California Civil Jury Instructions (CACI) 3903A.
[4] Florida Standard Jury Instructions in Civil Cases § 501.2(b).

medical expenses where plaintiff's claim incurred high damages for medical costs. This simple concept that medical damages claims must be reasonable presents the battleground in many liability cases. If a claimant has in fact paid for the medical services then the overwhelming body of law is that those amounts are deemed reasonable.[5] However in most litigated cases the vast majority of medical expenses remain unpaid. Plaintiff's present these numbers at trial or even before during pre-suit negotiations and the large medical costs drive the settlement numbers.

1. Defining the Reasonable Value of Medical Expenses

Courts have held that evidence of a reduced amount accepted as full payment under an agreement between the provider and private insurer is admissible and relevant to proving the plaintiff's damages for past medical expenses.[6] The concept is very simple. The value of a good or service is often determined through market forces. What a person accepts for a service is evidence of the value of the service. Some every day examples come to mind, like buying a house or car. It is not just what the seller wants that sets the price but what a buyer is willing to pay. But in our cases the dynamics are a little different. The Buyer (Plaintiff) and Seller (medical provider) have fixed the price before filing suit. The Buyer (Plaintiff) then turns around and asks a third party (Defendant) to accept this price. At a glance this seems unfair but making the defense's case is not without obstacles as discussed below.

2. Collateral Source Rule, Health Insurance, Medicare/Medicaid

Defendant's often take the position that the market value of a medical expense should be determined, at least in part, by what a provider accepts as payment. Conversely Plaintiff's often argue it is impermissible to inject insurance payments or collateral sources into a trial. This knee jerk reaction to disallowing insurance references in court room is not well founded.

"The policy justification for the collateral source rule is that the tortfeasor should not benefit from the expenditures made by the injured party or take advantage of contracts or other relations that may exist between the injured party and third persons."[7]

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[5] *See Bermudez v. Ciolek*, 188 Cal. Rptr. 3d 820, 835 (Cal. App. Ct. 2015)(explaining that a defendant's attempt to challenge paid bills will likely be unfruitful, but the reasonableness of unpaid bills usually turns on a wide-ranging inquiry).
[6] *Howell v. Hamilton Meats & Provisions, Inc.*, 257 P.3d 1130 (Cal. 2011).
[7] *Martinez v. Milburn Enters. Inc.*, 233 P.3d 205, 218 (Kan. 2010).

There is no absolute ban on discussing or mentioning insurance. In most of the disputed cases the plaintiff does not have available health insurance or has not submitted the claimed amounts through available insurance. Instead in most cases there is a payment arrangement called a "Letter of Protection", "Forbearance Agreement" or "Doctor's Lien". This agreement gives the doctor a lien on any settlement or judgment pending the outcome of the case. The plaintiff can treat with a doctor on a revolving credit line which they purportedly have to pay back at the conclusion of their case. The policy consideration above does not apply to this situation as no insurance was used at all. It is not impermissible under any evidence code to talk about insurance in general. The existence of the lien itself is in fact relevant and admissible at trial.[8]

Exceptions to the Collateral Source Rule

In several jurisdictions, the collateral source rule does not bar admission of an amount originally billed and the reduced amount accepted by the provider in full satisfaction because both amounts are relevant to prove the reasonable value of medical treatment.[9] In addition, just like any evidentiary rule, the same evidence disallowed for one purpose may be admitted for a different purpose.[10] Even if a court is persuaded that evidence of other insurance payments is related to the collateral source rule the evidence should come in as relevant to prove reasonableness or motive. For example if a person had available insurance which would have resulted in reduced liability for medical expenses the fact that this person willingly took on a higher debt could be relevant to establish the motivation for this choice was to enhance their damages case.

Medicare and Medicaid

Medicare is a federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease. Medicaid is a joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid also offers benefits not normally covered by Medicare, like nursing home care and personal care services. Medicare and Medicaid have readily and easily accessible rates for medial treatment that can be used for comparison purposes. Many doctors also use Medicare as a "base rate" and apply a multiplier of this rate to create their own charges. The Medicare rate is arguably low as a government type program but due to its comprehensive nature and scrutiny of medical procedures including peer reviews through CMS it provides a solid

[8] *Pack v. GEICO*, 119 So.3d 1284 (Fla. Dist. Ct. App. 2013) (LOPs are relevant to proving bias of a doctor and LOPs are admissible in evidence).

[9] *See Martinez*, 233 P.3d at 208; *Robinson v. Bates*, 857 N.E.2d 1195, 1200 (Ohio 2006)("Because no one pays the write-off, it cannot possibly constitute *payment* of any benefit from a collateral source."); *Stanley v. Walker*, 906 N.E.2d 852 (Ind. 2009); *Howell*, 257 P.3d at 1130.

[10] *Robinson*, 857 N.E.2d at 1198; *Howell*, 257 P.3d at 1146 (explaining that evidence of a reduced amount accepted by a provider from an insurer is admissible to rebut the plaintiff's contention that a bill is reasonable but is inadmissible to prove such payments were made by an insurer).

benchmark. In cases where the plaintiff is of Medicare age or Medicaid eligible bills submitted for payment must conform to Medicare allowable rates. The Social Security Act, Title XVIII Section 1848(g)(1-3) does not allow a medical provider to bill a Medicare beneficiary such as a Plaintiff in case, for medical charges that are not in line with the accepted payment under the Act. This is a protection afforded to all Medicare beneficiaries.

Since Medicare is considered a secondary payor and payments made when there could be another source or recovery are conditional payments there is a loophole in the defense's ability to force Medicare rates on all providers. Section 1802 of the Social Security Act gives the option to Medicare beneficiaries to enter into a private contract with a non-participating physician for services that would otherwise be covered under Medicare. *See* 42 U.S.C. 1395a. Such private contract must be in writing and contain several different beneficiary protections. Whether a doctor's lien or LOP is such a private contract has not been decided by any appellate court. Aside from the legal arguments on both sides regarding Medicare payments one must ask who is protecting the consumer? The rules limiting charges are intended to protect the plaintiff, why would an attorney be able to ethically allow his client be charged a higher amount?

3. Free Enterprise Practice of Medicine v. The Medical Business

Advances in Medicine and Health Care Costs

Advances in medicine including surgical techniques that are less invasive and have quicker recovery times have been a welcome progress in medicine. Many surgeries which would require hospital stays can now be done out patient at same-day surgery centers. Alongside these advances have come some controversy and increase in the volume of spinal procedures and overcharging for spinal procedures.[11] There is no question that these medical advances are good and quicker recovery times are even better. However, when it comes to submitting charges in the personal injury arena it is clear that quicker, more efficient, less invasive and same day surgical procedures, have not translated to reasonable charges.

Health care costs are rising and it is projected that between 2012 and 2022 healthcare spending will grow at 5.8%m which is 1% higher than our countries projected GDP.[12] This backdrop establishes health care costs will continue to rise and it is therefore imperative we have a good grasp on how to address medical damages.

Examples of Illegal Transactions

[11] Gregory Przybylski, MD, *Coding Clarity: High-Volume Spinal Codes Get Payer Scrutiny*, AANS Neurosurgeon, Vol.19 No. 1, 2010.
[12] CMS National Health Expenditure Projections 2012-2022.

Some transactions connected to medical billing agreements are expressly subject to criminal sanctions. The Anti-Kickback Statute prohibits paying remunerations to induce referrals for federal health care business. As of July 2009, thirty-six states and the District of Columbia had similar "anti-kickback laws," making it a criminal offense to knowingly offer, pay, solicit or receive a kickback or to induce or reward referrals, items, or services, which are reimbursable to a health care program.[13] Violations include hospitals paying physicians to refer patients to their facility or physicians paying recruiters to solicit business from patients in order to bill for unnecessary services under a healthcare program.

The Federal Stark Act expressly prohibits health care providers from referring patients to facilities or entities in which the provider has a financial interest. State laws addressing these self-referrals vary. Some states follow federal law, prohibiting most self-referrals. Others ban physicians from obtaining ownership interests in hospitals or facilities to which they refer patients. Several states merely require providers to disclose their financial interests to patients.[14] In performing discovery in our cases we should be alert to these types of issues as illegally rendered treatment may not be compensable.

Factoring and Sale of Accounts Receivables

Factoring is a commonplace business practice where a business sells their accounts receivable to a third party to assist in obtaining liquidity. Think of it as going to get an advance on your paycheck. In exchange for the risk of non-payment and waiting for the customer to pay the lender or “Factor” pays for the receivables at a discount. Typically this number varies but it is usually a fixed number around 10% or 20%. Factoring is not a loan.[15] Accounts receivable can also be purchased by an investor or third party who will hold on to the debt as an asset. Personal injury investment groups buy medical bills at a deep discount and hold on to them for the purpose of collecting the bill at the end of a case for a significant profit. This is different from factoring of receivables which typically includes cyclical purchase of receivables to assist in cash flow and avoid collections versus a pure investment with a huge mark up of 70-90% of the purchase price. For our purposes what is important is to understand is that these sales can be admissible in arguing the reasonable value of a medical service. The sales price can be used as an indicator of the market value. The obstacle we face in court is the misguided notion that plaintiff is on the hook for the full amount and therefore we should be barred from arguing that the purchase price is relevant.[16]

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[13] National Conference of State Legislatures, *Health Cost Containment and Efficiencies* (2010), http://www.ncsl.org/portals/1/documents/health/Fraud-2010.pdf.

[14] National Conference of State Legislatures, *Health Cost Containment and Efficiencies* (2010), http://www.ncsl.org/portals/1/documents/health/Fraud-2010.pdf. *Compare* Fla. Stat. § 456.053 (2016) *and* Ariz. Rev. Stat. § 32- 1401(25)(ff) (2016) *with* Conn. Gen. Stat. § 20-7a (2016).

[15] David B. Tatge and Jeremy B. Tatge, *Fundamentals of Factoring*, Practical Law The Journal, Sept. 2012, http://us.practicallaw.com/9-521-0970.

[16] *See Uspenskaya v. Meline*, 194 Cal. Rptr. 3d 364, 370 (Cal. Ct. App. 2015)(finding the fact that a provider “decides to sell a debt to a third party at a discount does not reduce the value of the services provided in the first place”); *Katiuzhinsky*

II. Defense Strategies

A. Discovery Tactics and Tools-Peeling the Onion

Damages are an essential element of a personal injury case. The Defendant must have the ability to investigate and rebut plaintiff's evidence. Therefore, the defendant is entitled to "narrowly drawn discovery to test what figure, if any, reflects reasonable surgery bills."[17] This discovery includes information pertaining to contradicting medical bills. In *Publix Super Mkts., Inc. v. Hernandez*, Hernandez sued Publix for injuries arising out of a slip and fall. Her claim included past medical expenses. During the course of discovery, Publix obtained two conflicting bills for Hernandez's hospital care. One stating her total care amounted to $18,708, which was paid in full by Performance Orthopedics for $6,490. The second stating her total care amounted to $54,233, which was paid in full by Peachtree Funding for $12,384. Publix deposed the hospital billing supervisor, who could not explain the discrepancy. Florida's Third District Court of Appeal held Publix was entitled to documents pertaining to various Peachtree entities' dealings related to the medical treatment of Hernandez. The court reasoned, "Publix's ability to defend against the damages element of Ms. Hernandez's cause of action would be eviscerated" without the information sought.

Discovery regarding the internal cost structure of a health care provider, the amount the provider accepts as payment from private non-litigation payors, and the discounts provided to different classes of patients is also relevant for a jury to determine whether the amounts billed to plaintiff are reasonable.[18] In *Columbia Hosp. v. Hasson*, Florida's Fourth District Court of Appeal found the trial court correctly balanced the hospital's trade secret interests with the defendant's need for information to dispute, as unreasonable, the amount of medical expenses the plaintiff sought to recover. The court upheld the denial of the hospital's motion for protective order.

In challenging exaggerated medical claims under doctor's liens discovery efforts must focus on uncovering the true value of the services charged. This can be done using traditional discovery tools in the form of deposition, interrogatories and subpoenas to non-parties.

Discovery Tools

Discovery should be tailored to investigating what billing practices a provider has as it pertains to amounts reimbursed from different sources, discounts in LOP cases, and any relationships that exist between a provider, referring attorneys, other practices, and even suppliers of medical equipment and ancillary services. There are two areas of

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v. Perry, 62 Cal. Rptr. 3d 309, 316 (Cal. Ct. App. 2007)(finding the trial court erred in limiting recovery for medical expenses to the amounts paid by a third party who purchased plaintiffs' accounts).

[17] *Publix Super Mkts., Inc. v. Hernandez*, 176 So. 3d 350, 352 (Fla. Dist. Ct. App. 2015).

[18] *Columbia Hosp. (Palm Beaches) Ltd. P'ship v. Hasson*, 33 So. 3d 148, 149 (Fla. Dist. Ct. App. 2010).

discovery that are intertwined in determining a fair price for the services. First the methodology for arriving at the bill being presented and second any "bias" discovery that is appropriate.

"You can be sure of succeeding in your attacks if you only attack places which are undefended."[19] The softer targets when it comes to discovery are not the expert witnesses trained in deposition questions but rather the office managers and the corporate designees who have access to the same information but likely not the same level of deposition expertise. Therefore it is advisable not to butt heads with an expert in a deposition over these issues but simply to find out who does their billing or who their office manager is. It is also not likely that one deposition will result in obtaining all needed information therefore it will often take several depositions to obtain what is needed. The *duces tecum* request as well needs to be tempered. The temptation is always to throw in the kitchen sink, but some times more targeted requests won't raise any eyebrows and avoid a protective order which protracts litigation. In general the subject matter of the deposition and items requested should be billing for the instant case, payments, sale of the bill, collections, and coding for the subject bill. During the deposition questions regarding insurance payments for similar services, reductions for letter of protections, number of cases or pending letter of protections with a particular law firm can be brought out.

A secondary source for information is the outpatient surgery centers. Typically they are less concerned about disclosing statistical data on a doctor. The frequency and the types of procedure similar or the same to the one performed along with the charges without disclosing HIPAA information is not hard for an ambulatory surgery to generate. In Florida these entities are regulated by the state and are already required to keep this information. Again, not overreaching in duces tecum or areas for deposition can result in a good source information. The surgery center will have its own bill generated that mirrors the surgeon's charges. In addition, it is important to develop how they generate their charges and how they compare to other payors as the bill from the surgical facility may be just as high as or higher than the surgeon's charges. It is appropriate to ask about costs of surgical equipment and hardware used.

The doctor of course will have to be deposed and asked questions about his services. Most of them will testify that they leave billing issues to their office manager. However the questions still have to be asked about what types of patients and sources of payments does the doctor have (Medicare, Workers Compensation, Insurance Contracts, Out of Net Work patients, and Doctor's Liens/LOP). The doctors lack of knowledge into his business practices is not only suspect to a reasonable juror but takes away the "indicia of reliability" for his charges. In addition, the issue of bias needs to be explored to determine referral relationships with lawyers, chiropractors, other practices, surgery centers and investors who buy their bills.

[19] SUN TZU, THE ART OF WAR (Lionel Giles trans., 1910).

Bias discovery on Plaintiff's experts is also a key component of any discovery on damages. After obtaining information on the billing practices, reimbursement, discounts etc. the jury still has to weigh the credibility and credence to give to the evidence. A jury staring at a six figure medical expense chart could have a difficult time overcoming simple arguments by plaintiff's counsel that the injured party is trying to skirt responsibility by challenging the incurred medical expenses. This is where bias discovery comes in to help tilt the scales back to where the jury understands that the doctor stands to benefit in this case as in other similar ones by overcharging. In Florida we have seen the evolution of case law allowing the playing field to become more even. A defendant is entitled to discovery that shows any relationship between an attorney and a law firm including payments obtained from a law firm to a provider.[20] Put together with evidence of overcharging and the doctor's interest in the outcome of the case, the jury will be more receptive to arguments that damages are truly inflated.

B. Trial Strategies

During trial, putting aside liability and causation arguments, the jury needs to be focused on reasonable damages. The stakes are now too high to leave damages unattended. During voir dire a party is allowed to discuss with the jury without disclosing the underlying facts, issues and their beliefs in relevant subjects.[21] It is too late to start discussing reasonableness of treatment, letters of protection, and health care costs, during opening statement. Jurors attitudes in these areas need to be explored using jury instructions that may have already been read to them depending on the jurisdiction in a discussion as to reasonable damages. There is a tug of war in jurors minds between taking responsibility for injuring someone and someone abusing the system by presenting inflated claims. If a defendant appears to be shirking its obligation the jury may close up to defense arguments but if the jury perceives plaintiff is trying to get a windfall they will close up to their arguments. Typical areas of questioning (without violating Golden Rule principles) are examples like "if I were to spill your coffee at dinner I should pay for it" but is it ok then for that person to get a $5.00 coffee to replace the $1.00 coffee he was having". Jurors have to understand the difference between plaintiffs having incurred bills versus asking the defendant to foot the entire inflated bill.

When the case starts questioning on the reasonableness of the bills has to be a central theme and addressed with each witness. Plaintiff needs to be asked if they tried to negotiate the bills, if they got a second opinion, if they even know what the charges are. The doctor needs to be asked whether he has a realistic expectation of being paid by plaintiff outside the lawsuit and whether he even discussed the fees in advance.

[20] *Neil Brown MD v. Mittelman*, 152 So. 3d 602 (Fla. Dist. Ct. App. 2014) (Discovery into LOPs and financial relationships is permitted and a direct referral is not needed).

[21] *See Depew v. Sullivan*, 71 P.3d 601 (Utah 2003)(explaining that a party is entitled to inquire about potential jurors' personal and even religious beliefs if pertinent to the issues at trial); *Babcock v. Northwest Mem'l Hosp.*, 767 S.W. 2d 705 (Texas 1989) (finding the trial court's refusal to allow questions during voir dire addressing the alleged "liability insurance crisis" and "lawsuit crisis" constituted reversible error).

The cross examination will also center on the doctor's deposition testimony that he doesn't really handle the billing aspects of his practice to make the point that this bill is speculative. Lastly, another area of inquiry is the coding of the bills which may result in overcharging or misleading description of procedures suggesting the wrong procedure or more complex procedures. Medical coding is the transformation of healthcare diagnosis, procedures, medical services, and equipment into universal medical alphanumeric codes (CPT).[22] The diagnoses and procedure codes are taken from medical record documentation, such as transcription of physician's notes, laboratory and radiologic results, etc. Coding is standard in medical practice. If CPT codes are not properly applied a bill can be unreasonable and inaccurate.

On the defense side of course an expert can help testify as to alternatives for the same services. Likewise a coder or billing expert can testify as to the typical or fair market value in the community for a similar service. For expert testimony in this area a doctor can be used, a coder, a hospital administrator or anyone having the sufficient qualifications to discuss this matter as an expert. Some courts limit the use of coders and experts in this area.[23]

In summary to adequately defend against inflated medical damages it is important to understand the legal concepts surrounding what is the reasonable value of a medical service and the obstacles faced in court when trying to challenge damages. Through discovery efforts tailored to understand the methodology of charges submitted in cases as well as bias discovery to expose any financial motivations by the providers or litigants we can chip away and present to a jury a fair analysis of the damages claimed.

[22] CPT is Current Professional Terminology, a system developed by the American Medical Association for standardizing the terminology and coding used to describe medical services and procedures.

[23] *State Farm Mut. Auto. Ins. Co. v. Bowling*, 81 So. 3d 538, 541 (Fla. Dist. Ct. App. 2012)(finding the trial court abused its discretion in excluding the testimony of a medical billing coding expert to establish the reasonableness of plaintiff's bills).