AFFORDABLY PRESENTING AND DEFENDING MEDICAL DAMAGES

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Permian Basin TLA

Midland, TX

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CHOOSING MEDICAL PROVIDERS

- Treatment records v. narratives requested by counsel.

  Tex. Employer's Ins. Assoc. v. Sauceda, 636 S.W.2d 494 (Tex. App. – San Antonio 1982). (TAB A).

- Difference with med-legal records
- LOPs
- Familiar with liability work
- Cost and payment options

PAYING MEDICAL PROVIDERS

- Verbal or written agreement to protect
- Deposit arrangement
- Self-pay rate
- Health insurance or government program
- Medical funding

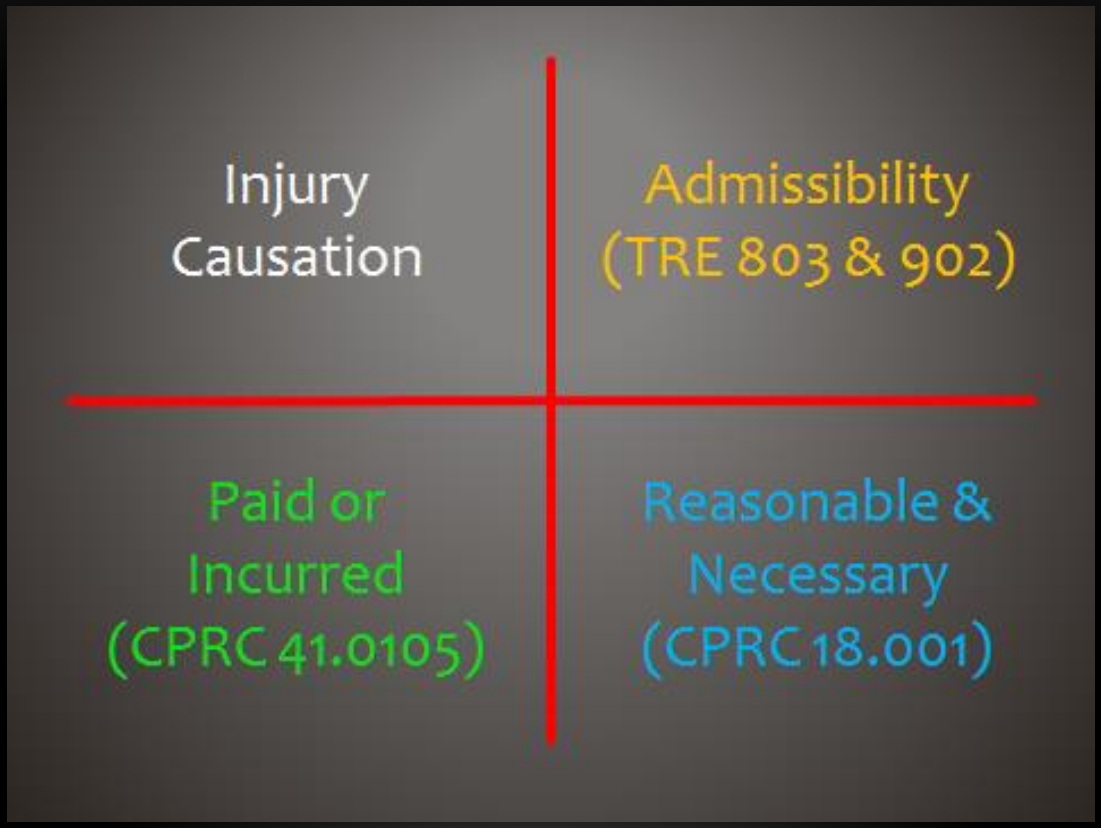
GETTING RECORDS & BILLS
(TAB B)

- HB300 (15 BIZ DAYS) TEX. HEALTH & SAFETY CODE §181.102
- COST
  - WITNESS FEE (RECORDS) CPRC §22.004
  - WITNESS FEE (TESTIMONY) CPRC §22.001
  - RECORD COPYING FEES
    - HOSPITAL - TEX. HEALTH & SAFETY CODE §241.154(b)-(d)
    - DOCTOR – 22 TAC 165.2

GETTING RECORDS & BILLS (CONT.) (TAB C)

- NEW GUIDANCE FROM HHS ON 45 CFR §164.524
- REQUESTS BY PATIENT FOR ELECTRONIC COPY OF RECORDS MAINTAINED IN ELECTRONIC FORM
  - ACTUAL "ALLOWABLE COST"
  - AVERAGE "ALLOWABLE LABOR COSTS"
  - $6.50 FLAT FEE
- NOT REQUESTS VIA SUBPOENA OR HIPAA AUTHORIZATION
- USE LETTER FROM CLIENT (TAB D)

PRESENTING MEDICAL DAMAGES



Reasonableness

Price that a willing owner would sell and a willing purchaser would buy, but neither being under any obligation to do so

CPRC §41.0105 and *Haygood**

Amount that has been paid or will be paid by or on behalf of the plaintiff

* *Haygood v. de Escabedo*, 356 S.W.3d 390 (Tex. 2011).

"PAID OR INCURRED"
(IF INSURANCE)

- CPRC §41.0105 and *Haygood* will cap what is submitted and recovered at the amount that has been or will be paid by plaintiff or insurance.

- Defense is likely to agree that reimbursed amounts = reasonable.

“PAID OR INCURRED”
(IF INSURANCE)

- Stipulation (TAB E)

- If no stipulation, file a motion. (TAB F)

"PAID OR INCURRED" (IF INSURANCE)

- **But, can we still introduce the full bill amounts, possibly as evidence of the significance of the injuries?**
  - Defense argues no. *Haygood* says, "…any relevance of such evidence is substantially outweighed by the confusion it is likely to generate, and therefore the evidence must be excluded."
  - Plaintiff argues yes. *Henderson v. Spann*, 367 S.W.3d 301 (Tex. App. – Amarillo 2012, pet denied) (…"the post-verdict adjustment method is inadequate to account for or remedy any effect the inadmissible evidence of unadjusted past medical expenses may have had on the jury's assessment of non-economic damages.").

"PAID OR INCURRED"
(IF INSURANCE)

- **But, can we at least tell the jury that the medical expenses are discounted because they were paid by health insurance?**
  - Defense argues no. *Haygood* says, "Accordingly, we hold that only evidence of recoverable medical expenses is admissible at trial….[T]he jury should not be told that they will be covered in whole or in part by insurance. Nor should the jury be told that a health care provider adjusted its charges because of insurance."
  - Plaintiff argues yes. (TAB G). Kostura's discussion of TRE 411, *Univ. of Texas at Austin v. Hinton*, 822 S.W.2d 197 (Tex. App. – Austin1991, no writ) and its progeny.

"PAID OR INCURRED"
(IF DON'T USE INSURANCE)

- **CPRC Chapter 146** says medical provider must bill insurance OR if the provider is not required or authorized to bill insurance, bill the patient. CPRC §146.002.

- **When is a provider not "authorized" to bill insurance?**
  - Insurance denies claim because they are secondary.
  - Patient instructs provider not to submit.
    - Not a failure to mitigate. *City of Fort Worth v. Barlow*, 313 S.W.2d 906 (Tex. App. – Ft. Worth 1958); RESTATEMENT (SECOND) OF TORTS §918(1), n. 31. (TAB H)
    - HIPAA (HITECH Act) "opt-out" provision.

PROVING REASONABLENESS

- Expert testimony
- CPRC §18.001 affidavit
- Federal court (TAB I). *Rahimi v. USA,* 474 F.Supp.2d 825 and *Cardner v. Home Depot USA, Inc.,* 2006 U.S. Dist. LEXIS 25283

PRESENTING IT TO THE JURY

- Treating doctors or therapists…or not. *(TAB J)*
  - *Guevara v. Ferrer, 247 S.W.3d 662 (Tex. 2007)*
  - *JLG Trucking, LLC v. Garza, 466 S.W.3d 157 (Tex. 2015)*
- Live or video depo (TAB K)
- Video DWQs (TAB L)
- Demonstrative aids (TAB M)

DEFENDANT'S RESPONSE

- Attack custodian qualifications
- File contraverting affidavit
- Hire expert on reasonableness of past med exps
- Attempt to limit evidence (funding companies)

ATTACKING CUSTODIAN'S QUALIFICATIONS

- DWQ's asking about custodian's medical expertise
  - *Johnson v. Protective Ins. Co*., 1999 Tex. App. LEXIS 2696 (Tex. App. – Houston (14th Dist., Apr. 8, 1999) (unpublished).

- File motion to quash (TAB N)
- Objection to medical funder's affidavit (TAB O)

CONTRAVERTING AFFIDAVITS

- If no contraverting affidavit, evidence excluded.

  Beauchamp v. Hambrick, 901 S.W.2d 747 (Tex. App. – Eastland 1995, no writ).

- If contraverting affidavit,
  - Conclusory
  - Not qualified
  - Improper basis

PLAN OF ATTACK

- Strike contraverting affidavit (TAB P)
- Depose “defense expert” (TAB Q)
- Strike defense “expert” (TAB R)

STRIKE DEFENSE EXPERTS

attached documents do not indicate or reflect the amount of money paid by [redacted] to purchase the billing and the amount of any discount received by [redacted] The affidavit and attached documents do not contain the availability and application of insurance payments or offsets, or other discounts or credits which might be used to reduce the amounts paid. The documents attached to this [redacted] affidavit do not contain an itemized statement of services and charges from each provider. An itemized medical billing statement is a formal document that identifies charges assessed for medical services and products, the dates of service, any discounts, credits, offsets, and payments, and must contain current, applicable, and appropriate ICD9 and CPT codes for each such charge. This [redacted] affidavit and the records attached thereto do not contain this customary, necessary, and required information. The services and charges are not reasonable and necessary.

The services and charges are not reasonable and necessary.

and attached documents do not indicate or reflect the availability and application of insurance payments or offsets or other discounts which might be used to reduce the amounts paid. Dr. [redacted] died in August 2012, and the affidavit is dated after the date of his death. The services and charges are not reasonable and necessary.

11. The opinions rendered in this case are the opinions of the evaluator, and have been rendered to a reasonable degree of medical probability. This evaluation has been conducted on the basis of the medical documentation provided with the assumption that the material is true, complete, and correct. If more information becomes available at a later date, then additional services, reports, or reconsideration may be requested. Such information may or may not change the opinions rendered in this evaluation. This opinion is based on a clinical assessment from the documentation provided.

LACK QUALIFICATIONS

- Being a doctor is not enough
- Experience in billing, collecting, auditing, or approving/denying payment
- Make them show their methodology
- Make them bill the procedure

LACK PROPER METHODOLOGY

[redacted]

Phone: [redacted] Fax: [redacted]

October 31, 2012

[redacted] Attorney at Law

[redacted]

Austin, TX 78705

Since the Centers for Medicare and Medicaid Services (CMS) is now driving reimbursements nationwide, and most commercial insurance plans like Blue Cross Blue Shield, Humana, Aetna, Cigna and United Healthcare as well as worker's compensation plans are offering contracts to medical providers based on the Medicare Fee Schedule, it is reasonable to use this Medicare Fee Schedule as a basis for determining a reasonable reimbursement in cases like these. The Centers for

As you are aware, hospitals and medical providers can charge whatever they want. The problem is determining what is a reasonable amount to actually pay for these medical services?

The Usual and Customary fee is defined as the charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area. To determine the Usual and Customary fee for a specific medical procedure or service in a given geographic area, insurers often analyze statistics from a national study of fees charged by medical providers, such as the data base profile set up by the Health Insurance Association of America (HIAA). Some insurers compile their own data using their own claim information. The insurers use these statistics to chart a range of fees for each geographical area in which services are provided. Then the insurer pays all or part of the claim, depending on whether the amount of the claim is within the Usual and Customary allowance.

The phrase "usual, customary, and reasonable" (UCR) refers to the base amount that third-party payers (including insurance carriers and employers) generally use to determine how much will be paid, on behalf of an enrollee, for services that are reimbursed under a health insurance policy or health plan. Generally, payment for health care services is based on UCR rates: most coverage or reimbursement is only a

“UCR” = USUAL CUSTOMARY AND REASONABLE

[redacted]

Phone: [redacted] Fax: [redacted]

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separate issue outside the scope of this audit. This review also does not reflect any payments by Liberty Mutual, the carrier for the worker's compensation claim for this same injury.

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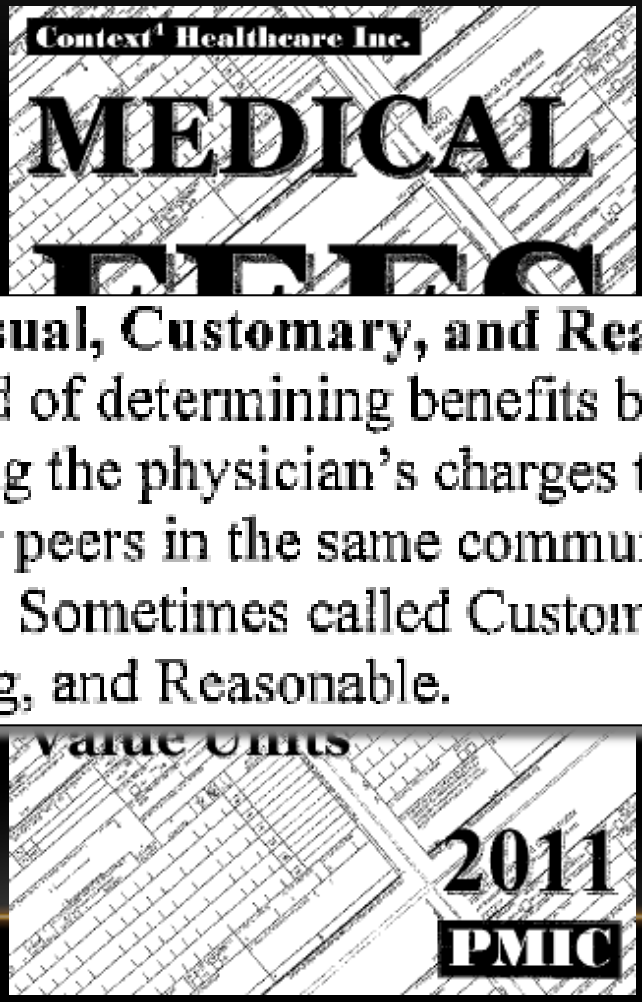
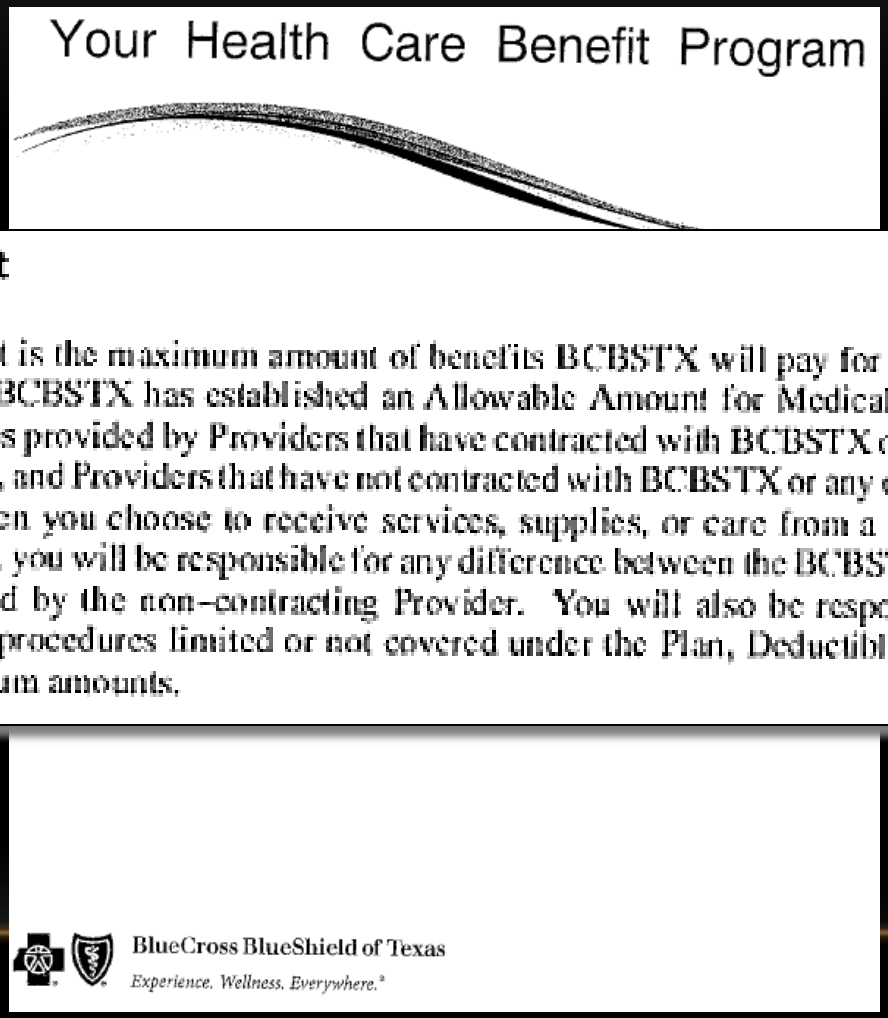


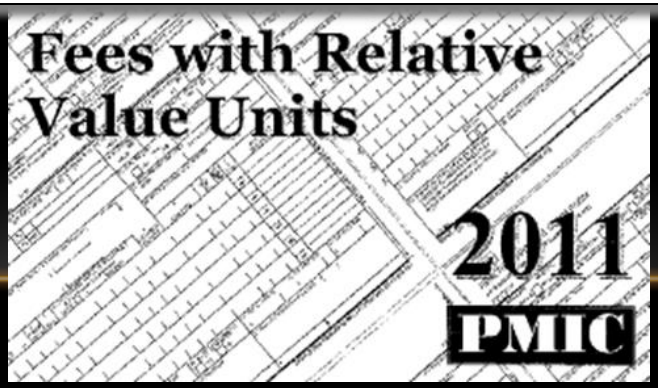
UCR [Usual, Customary, and Reasonable]: A method of determining benefits by comparing the physician’s charges to those of his or her peers in the same community and specialty. Sometimes called Customary, Prevailing, and Reasonable.

ALLOWABLE AMOUNT



ALLOWED CHARGE

Allowed charge [approved charge]: The amount Medicare approves for payment to a physician. Typically, medicare pays 80 percent of the approved charge and the beneficiary pays the remaining 20 percent.



SELF PAY RATES

- Usually requires payment up front
- Even if they have the money, not required to do.
- Plaintiff not required to take such extraordinary efforts to mitigate damages. RESTATEMENT (SECOND) TORTS §918(1).
- Can even recover for exorbitant amounts that plaintiff was reasonable in paying (or incurring) in order to avoid further harm. RESTATEMENT (SECOND) TORTS §911, cmt h.

MEDICAL FUNDING PAYMENTS (TAB S)

- No payment made “by or on behalf of” plaintiff.
- Payment is a purchase of the account, not a payment on the account.
- Plaintiff “incurred” and is obligated to pay the entire bill. No windfall.
- Even if provider writes-off balance after sale, not material.
- Again, what is the price that the willing provider sold to the willing patient?
- The price the factor paid was not for the services, but for the right to collect for the services.

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THANK YOU

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