DETERMINING REASONABLENESS OF MEDICAL EXPENSES

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SETTING THE STAGE

- **In 2003, CPRC 41.0105:**
  - "…recovery of medical or health care expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant."
- **In 2010*, Haygood v. de Escabedo***
  - Limited recovery and evidence
  - "actually paid or incurred" = expenses that have been or will be paid by or on behalf of claimant.
  - Evidence of full medical charges is inadmissible.
- **In 2012 and 2015, *Big Bird Tree Serv., v. Gallegos and Katy Springs & Mfg. v. Favalora***
  - Confirmed that "actually paid or incurred" is determined from the perspective of the claimant at the time of the service.

WHAT ARE THEY TELLING US?

- If our clients choose to use their health insurance, they will be limited to recovering and presenting evidence of only the amounts the client and their insurer paid.
- *BUT*, if our clients choose to incur the full amount of the medical expenses, that is what they can present evidence of and recover.

AFFECTS ENTIRE DAMAGE MODEL

- Past meds limited to what was paid
- Lower past meds implies less serious injury, potentially reducing noneconomic damages
- Lower past meds can make future care plan look inflated

POTENTIAL SOLUTIONS

- If use health insurance, inform jury that plaintiff will have to pay insurance benefits back. *Univ. of Texas v. Hinton*, 822 S.W.2d 197 (Tex. App. – Austin 1991, no writ). (TAB A).

- Don't present evidence of past meds

- Don't use insurance

WHY PLAINTIFF DID NOT USE THEIR HEALTH INSURANCE?

- Couldn't afford co-pays
- Couldn't afford co-insurance
- Couldn't afford deductible
- Provider not in network
- Provider would not accept health insurance on a third party liability claim
- Health insurance denied because it was not primary
- Was worried about being dropped or increased rates
- Did not want to reduce lifetime benefits

PAYING MEDICAL PROVIDERS

- Verbal or written agreement to protect (LOP)
- Deposit arrangement
- Medical funding

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

PROVING REASONABLENESS

- CPRC 18.001 affidavits
- Treating physician
- Life care planner
- Third party service – be careful who you choose

TYPICAL DEFENSE ATTACKS

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

ATTACKING CUSTODIAN'S QUALIFICATIONS

- Defense DWQ's asking about custodian's medical expertise
  - File motion to quash defense questions (TAB B)
  - *NOTE: Johnson v. Protective Ins. Co.,* 1999 Tex. App. LEXIS 2696 (Tex. App. – Houston (14th Dist., Apr. 8, 1999) (unpublished). (TAB C)
- Defense attack of medical funder affidavits (TAB D)
  - *Katy Springs & Mfg., Inc. v. Favalora, 476 S.W.3d 579 (Tex. App. – Houston (14th Dist.] 2015, pet denied).*

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

DEALING WITH CONTROVERTING AFFIDAVITS

- Strike controverting affidavit (TAB E)
- Depose defense “expert” (TAB F)
- Strike defense “expert” (TAB G)

CONCLUSORY AFFIDAVITS

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.

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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

DEFENSE ATTEMPT TO LIMIT EVIDENCE – CHAP 146

- **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 "required" or "authorized" to bill insurance?**
  - Health insurance is secondary.
  - Patient instructs provider not to submit.

DEFENSE ATTEMPT TO LIMIT EVIDENCE – FAILURE TO MITIGATE

- Plaintiff is not obligated to use their health insurance.
- Is not a failure to mitigate. *Guzman v. Jones*, 804 F.3d 707 (5th Cir. 2015); *City of Fort Worth v. Barlow*, 313 S.W.2d 906 (Tex. App. – Ft. Worth 1958); RESTATEMENT (SECOND) TORTS §918(1), n. 31. (TAB H)
- Plaintiff can recover for exorbitant amounts that they were reasonable in paying (or incurring) in order to avoid further harm. RESTATEMENT (SECOND) TORTS §911, cmt h.

DEFENSE ATTEMPT TO LIMIT EVIDENCE – FAILURE TO MITIGATE

- Use of health insurance usually requires some patient cost.
  - Deductible
  - Co-insurance
  - Co-pay

- Plaintiff not required to take such extraordinary efforts to mitigate damages. RESTATEMENT (SECOND) TORTS §918(1).

DEFENSE ATTEMPT TO LIMIT EVIDENCE - MEDICAL FUNDING PAYMENTS (TAB I)

- Again, what is the price that the willing provider sold to the willing patient?
- Patient incurred the full amount of the bill. No windfall.
- Factor's payment is a purchase of the account, not a payment on the account.
- No payment made "by or on behalf of" plaintiff.
- The price the factor paid was not for the services, but for the right to collect for the services.

DEFENSE ARGUMENT THAT PAYMENT FOR DEBT = REASONABLE CHARGE

- What is reasonable price for medical service? NOT, what is reasonable price for medical debt.
- Reasonable price = willing buyer will pay a willing seller
- Willing buyer is patient
- Willing seller is provider
- Criteria used in deciding whether to buy debt very different

DEFENSE “EXPERTS”

- DME doc’s
- Nurses
- Biller/Coders
- Oftentimes making necessity opinions
- Basing opinion on payment data

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?

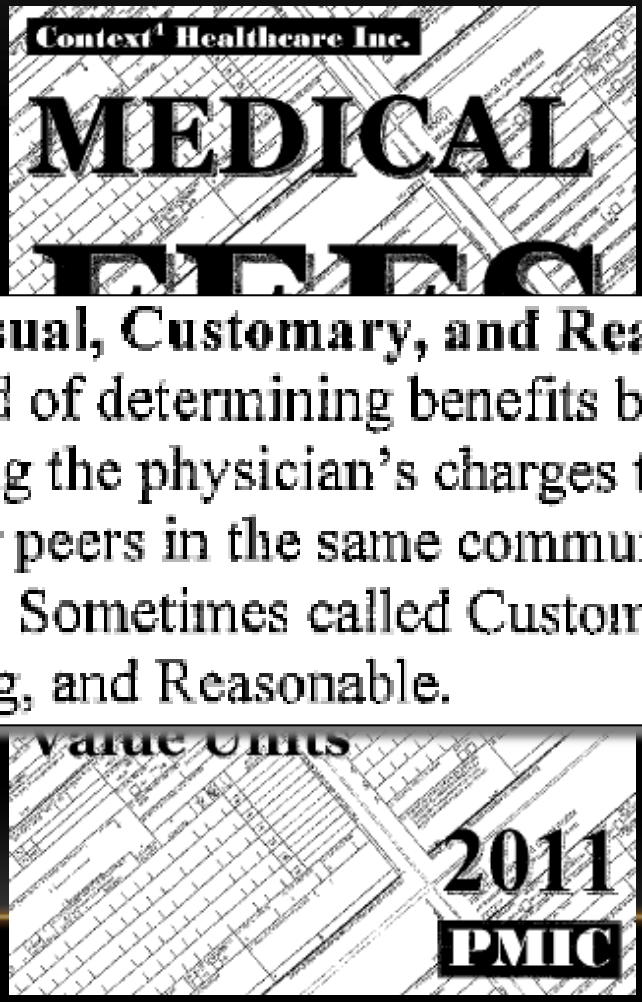
The Usual and Customary fee is defined as the charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area. To determine the Usual and Customary fee for a specific medical procedure or service in a given geographic area, insurers 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

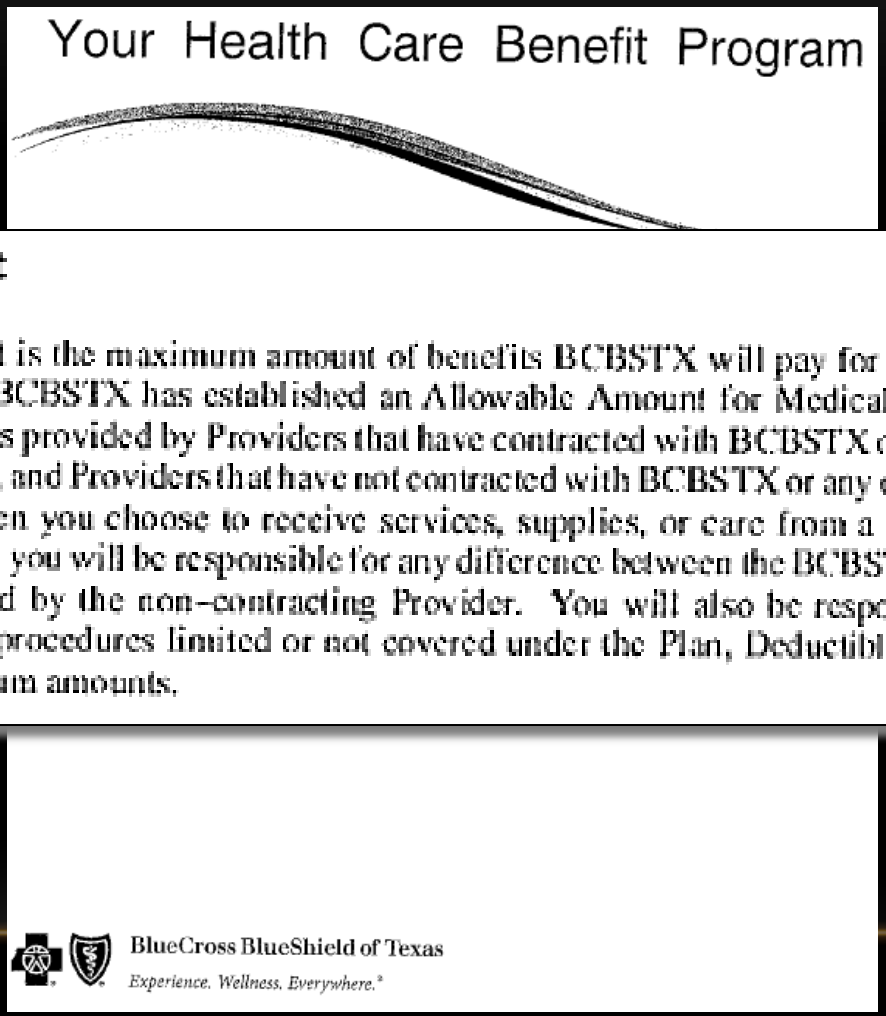
- **AMA Policy H-385.923 Definition of "Usual, Customary and Reasonable" (UCR)**
  - a 'usual' fee means that fee usually charged, for a given service, by an individual physician to his private patient (i.e., his own usual fee);
  - a 'customary' fee is within the range of usual fees currently charged by physicians of similar training;
  - a 'reasonable' fee meets the above two criteria and is justifiable, ***considering the special circumstances of the particular case in question, without regard to payments that have been discounted under governmental or private plans***.
  - [T]here is ***no relationship between the Medicare fee schedule and Usual, Customary and Reasonable Fees***. (Res. 109. A-07; Appended: Res. 107, A-13).

“UCR” = USUAL, CUSTOMARY AND REASONABLE



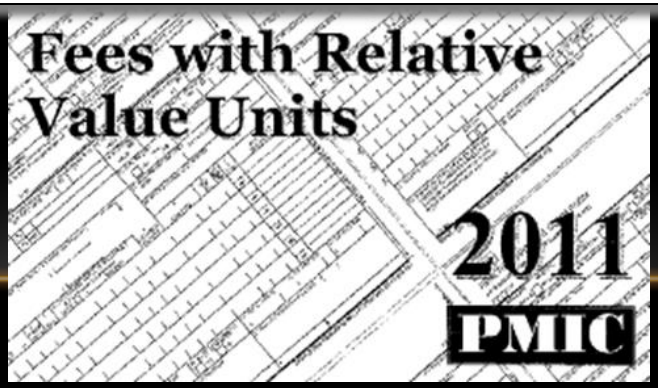
UCR [Usual, Customary, and Reasonable]: A method of determining benefits by comparing the physician’s charges to those of his or her peers in the same community and specialty. Sometimes called Customary, Prevailing, and Reasonable.

"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.



CHARGES, NOT PAYMENTS

- Charges are only relevant figure when dealing with patients who are not insured.
- Payments are the product of the bargaining position of the parties involved in that transaction. If client or client's payor was not part of transaction, then those payments are not applicable.
- Payments do not include "in-kind" benefits, so do not reflect the true value of the medical services.
- Even calculating payments can be difficult. Put them to the task of coding, billing and reimbursing the procedure.

EXAMPLES OF "IN-KIND" BENEFITS

- Exclusivity
- Bonuses based on patient volume
- Accelerated payment terms
- Limited time period for denials
- Dedicated staff at the payor to assist the provider
- Marketing assistance by listing provider on payor's website or catalog
- Accelerated appeals of denials
- Assistance in hiring staff and physicians
- Enhanced reporting to provider
- Access to payor's electronic system for submitting claims and transferring funds

DON'T PLAY INTO THEIR HAND

- Our arguments are sound and will prevail, unless we defeat ourselves, such as:
  - Doing business with providers or funders who have outrageous charges
    - a 50% reduction off of an inflated bill still means you paid too much. Be a smart consumer for your clients.
    - Inflated bills inject issues into your case
    - Inflated bills increase likelihood will end up in trial
  - Being hypocritical when arguing with lienholders

THANK YOU

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