Challenging *Baptist Healthcare v. Miller*

STEPHEN S. BURCHETT

JACKSONKELLY PLLC

Scope of Presentation

1. Brief
2. Humorless
3. No war stories
4. Leave time for questions/collaboration at end

Two Precedents That Should be Overturned

1. Any physician can testify about any specialty. (*Kabai*)
2. Plaintiff can recover full amount of “billed” medical expenses even if this results in windfall. (*Baptist Healthcare v. Miller*)

Baptist Healthcare v. Miller decision, 2005

Background

- Phlebotomist applied tourniquet
- Left 80 year-old patient unattended for approximately 10 minutes
- Patient “experienced medical complications”
- Plaintiff sought $40,922.08 in medical expenses
  - $31,840 billed by treating physician
  - $3,356.38 paid by Medicare
- 2 Day trial
- $154,000.00 award
- Reduced by 35% comparative fault
- $101,100 verdict

Baptist Healthcare v. Miller decision, *2005*

<u>Procedural History</u>

- Motion for Directed Verdict to limit recovery to what Medicare paid
- Trial court reserved ruling and then denied motion
- Facility appealed
- Court of Appeals affirmed
- Supreme Court affirmed

Baptist Healthcare v. Miller decision, *2005*

<u>The *Baptist Healthcare* Court</u>

- Lambert, Chief Justice, delivered opinion of the Court
- Graves
- Johnstone
- Roach
- Scott
- Wintersheimer

Baptist Healthcare v. Miller decision, *2005*

Majority Opinion (4 conclusory paragraphs)

- Relied on the collateral source rule.
- Because participants pay into Medicare, benefits are governed by the collateral source rule and are treated the same as other types of insurance.
- The injured party should receive any windfall and not the tortfeasor.
- Decision still ONLY entitles the plaintiff to recover the "reasonable value" of medical expenses.

Baptist Healthcare v. Miller decision, *2005*

<u>Justice Cooper's Dissenting Opinion</u> (5 ½ pages)

- Medicare reimbursement is not truly negotiated.
- Collateral source does not apply to "this kind of phantom expense that was never incurred."
- Cited case law from California, Florida, Idaho, Kansas, New York, Pennsylvania and Virginia.

Majority Rule?

What Other Courts Have Done:

- Statute
- Reasonable Value analysis
- Collateral Source analysis
- Benefit of Bargain analysis
- Medicaid exception

Majority Rule?

- Required Reading Survey Cases;

  Wills v. Foster, 892 N.E.2d 1018 (Ill. 2008)

  Swanson. Brewster, 784 N.W.2d 264 (Mn. 2010)

- Cooper dissent as well-written as any "anti-*Baptist Healthcare v. Miller* decision"

  Hanif v. Housing Authority of Yolo County, 246 Cal.Rptr. 192 (Cal. Ct. App. 1988)

  Moorhead v. Crozer Chester Medical Ctr., 765 A.2d 786 (Pa. 2001)

- Precise national analysis outside scope of this presentation because there is no clear majority/minority rule.

Majority Rule?

1. Plaintiff's claim limited to amount paid OR amount paid equals "reasonable value."

   California, Idaho, Montana, Pennsylvania

2. Plaintiff recovers full value OR plaintiff recovers full value when plaintiff has paid some consideration, including Medicare.

   Arizona, Delaware, Georgia, Kansas, Kentucky, Missouri, Virginia, Washington, D.C.

3. Medicaid write-offs not recoverable.

   Kansas, Louisiana, Rhode Island

Majority Rule?

4. Recover Reasonable Value.

Arkansas, New Mexico, South Dakota, Hawaii, South Carolina, Mississippi, Texas, Wisconsin

Plaintiff is entitled to recover *VALUE* even if no liability – Restatement 2nd Torts 924 (comment *f)*

a. Both paid and billed can be introduced. Ohio

b. Exclude paid amounts but leave open option to introduce other evidence (experts) as to "reasonable amounts." Illinois

5. Reduction/Admissibility of Paid Amounts by Statute.

Florida, Massachusetts, Minnesota, Oregon

Current Supreme Court of Kentucky

- Minton – Fletcher appointee
- Hughes – Fletcher appointee
- Lambert
- VanMeter – Republican
- Keller – Beshear appointee
- Wright
- Buckingham – Bevin appointee

Medicaid Argument

Motion practice is recommended that *Baptist Healthcare v. Miller* does not apply to Medicaid reimbursement because patient does not pay into Medicaid.

Factual Basis of *Baptist Healthcare v. Miller*

Nature of Medical Charges

- "Full medical charges" are based upon "chargemaster"
- Inflated over actual costs or revenue
- Can be useful for tracking goods and services
- Virtually all payments for inpatient care have no relationship to chargemaster
- Largely, chargemaster has no relationship to any Medicare billing
- Medicare is benchmark
- Billing is distinguished from charging
- Every facility is different
- Facilities NEVER receive 100% of chargemaster

Factual Basis of *Baptist Healthcare v. Miller*

- Actual Reimbursement is Largely Prospective
  - “Diagnostic Related Groups” (DRGs) – Hospitals
  - “Current Procedural Terminology” (CPTs) – Outpatient / Physician
- Hospitals submit UB-04 Form
  - (Medicare ID, DRG Code, Length of Stay, Diagnosis code, CPT code)
- Physicians submit CMS-1500 Form (CPT code)
- **ACTUAL BILLS** are the **UB-04 Form** and **CMS-1500 Form**
- Medicare (and similarly, Medicaid and private insurers) NEVER see chargemaster invoice

PAGE ___ OF ___

CREATION DATE

TOTALS

HEALTH INSURANCE CLAIM FORM

PLEASE PRINT OR TYPE

JACKSONKELLY PLLC

Make a Record

- Depose 30(b) Representative of Facility / Provider
- Chargemaster has no relationship to actual costs or charges

  Chargemaster is a fiction

  Illustrate fiction by individual charges

  Establish that CMS-1500 and UB-04 are actual invoices

Expert Proof on Reasonableness

- Accountant to Simply Address Inaccuracies in Chargemaster
  - No real foundation in fact.
  - Not true bill.
  - No incentive to make accurate.
  - Duplicate charges.

- Billing expert
  - Chargemaster is pure fiction.
  - No basis in fact.
  - Explain Medicare / Medicaid / insurance billing.

CR 19 Motion Practice - Medicaid

CR 19.01 – "A person who is subject to service of process… shall be joined as a party in an action… if he claims an interest related to the subject of the action and is so situated that the disposition of the action in his absence may… leave any of the persons already parties subject to a substantial risk of incurring double, multiple or otherwise inconsistent obligations by reason of the claimed interest."

CR 17 Motion Practice - Medicaid

CR 17.01 – "Every action shall be prosecuted in the name of the real party in interest…"

CR 19 / CR 17 Motion Practice - Medicaid

KRS 205.624(1) – "An applicant or recipient shall be deemed to have made to the cabinet an assignment of his rights to third-party payment to the extent of medical assistance pain on behalf of the recipient under Title XIX of the Social Security Act."

KRS 205.624(2) – "The cabinet shall have the right of recovery which a recipient may have for the cost of hospitalization, pharmaceutical services, nursing services, and other medical services, not to exceed the amount of funds expended by the cabinet for such care and treatment of the recipient under the provisions" of the Act.

CR 19 / CR 17 Motion Practice - Medicaid

- Assignee becomes the owner of the cause of action and is the real party in interest.

  Louisville & N.R. Co. v. Mack MFG. Corp., 269 S.W.2d 707, 709 (Ky. 1954)

- Defendant has the right to have the assignee joined to pursue the claim in its own name.

  Works v. Winkle, 234 S.W.2d 312, 316 (Ky. 1950)

Motion in Limine – Collateral Source Rule

- **Introduction of write-offs does NOT violate collateral source rule:**

"The written-off amount of a medical bill differs from the receipt of compensation of services…"

"Because no one pays the negotiated reduction, admitting evidence of write-offs does not violate the purpose behind the collateral source rule. The tortfeasor does not obtain a credit because of payments by a third-party on behalf of the plaintiff."

Robinson v. Bates, **857 N.E.2d 1195, 1200 (Oh. 2006)**

Economics

Does this make financial sense in all cases?

- $30,000.00 in medical bills and $3,000.00 paid — Unlikely
- $1,000,000.00 in medical bills and $100,000 paid — Certainly

Economics

- Average Large Exposure Case:

  $500,000.00 in medical bills / $50,000 paid / $50,000 lien
  $1M-1.2M exposure
  30% chance to win
  $600,000.00 - $700,000.00 valuation

- Mediation
  Lower settlement value by $50,000 - $100,000.00
  Well worth effort

- Necessary record for any appeal

Legislation

In any civil action for personal injury wherein the plaintiff seeks recovery of past medical expenses, the trial court shall:

a. Limit any introduction of medical expenses to the actual amount of medical expenses paid by the plaintiff and/or any third-party payor,

and

b. After any verdict awarding past medical expenses, remit any judgment for medical expenses to the actual amount of medical expenses paid by the plaintiff and/or any third-party payor.

Summary

1. Utilize *Baptist Healthcare v. Miller* (both Majority and Dissent)

2. Make a Record – Chargemasters NOT Reflective of Actual Bills

3. Conduct Focused Expert Proof

4. Consider CR 17 / 19 Motion Practice

5. Consider Collateral Source Rule Motion Practice

6. Propose Legislation

Query/Discussion

- Has anyone tried anything different?
- Any other ideas?
- Has anyone had any success?

Benediction

- MAKE A RECORD – please☺
- Caution against appealing unless you have solid record
- Does it make sense to limit any discussion about an appeal to Medicaid cases?
- Take the position that, collectively, we ARE getting *Baptist Healthcare* reversed so that it is essentially a "done deal."
- Communicate/Work together
- Encourage legislative reform

Stephen S. Burchett
(606) 316-0060
(859) 288-2846
stephen.burchett@jacksonkelly.com

JACKSON KELLY PLLC