Journal of Consumer Attorneys Associations for Southern California
ADVOCATE
July 2015 Issue

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Medical liens: dealing with bias and character issues at trial

Emboldened by *Howell*, the defense takes aim at medical liens introduced to prove past meds

When the client has received medical treatment on a lien there are bias and character issues that may arise at trial. The defense will try to show that the medical practitioner has a "financial stake" in the outcome of the case and therefore will give biased testimony towards the plaintiff. There is also the potential that the defense will argue the plaintiff failed to mitigate her damages by choosing to go with a lien doctor when the plaintiff was covered by insurance that would not have involved the plaintiff incurring a debt. The defense argument is that "something is not right with the arrangement" or the plaintiff "is not mitigating her damages."

Stipulation

The best practice is to try to reach a stipulation with opposing counsel regarding the amount of past medicals. This eliminates the issue of the jury hearing how much may have been paid by health insurance as the "collateral source rule" is still the law in California. (*Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541, 556.)

If a stipulation is reached as to the amount of reasonable and necessary medical bills incurred by plaintiff, then clearly any attempt to refer to the fact that the plaintiff has treated on a lien is irrelevant. Pursuant to Evidence Code section 350 "No evidence is admissible except relevant evidence." With a stipulation as to the amount of reasonable and necessary medical bills, defense counsel's argument on relevance is now gone.

Motion in limine

Assuming opposing counsel will not stipulate to the reasonable and necessary amount of past medical bills, and seeks to bring up the fact that plaintiff treated with one or more providers on a lien basis, the best practice is to seek to keep out said evidence with a motion *in limine* pursuant to Evidence Code section 352.

> A motion *in limine* is made to exclude evidence before the evidence is offered at trial, on grounds that would be sufficient to object to or move to strike the evidence. The purpose of a motion *in limine* is to avoid the obviously futile attempt to 'un-ring the bell' in the event a motion to strike is granted in the proceedings before the jury.

(*Hyatt v. Sierra Boat Co.* (1978) 79 Cal.App.3d 325, 337; *3 B. Witkin, California Evidence* (3rd ed. 1986)

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Introduction of Evidence at Trial, § 2011, p. 1969.)

The Evidence Code section 352 motion has the importance not only to accomplish exclusion of harmful testimony or other evidence, but in preserving the right to appeal the ruling. (*People v. Morris,* (1991) 53 Cal.3d 152, 188; *People v. Jennings* (1988) 46 Cal.3d 963, 976.)

Evidence Code section 352 states:

> The court in its discretion may exclude evidence if its probative value is substantially outweighed by the probability that its admission will (a) necessitate undue consumption of time or (b) create substantial danger of undue prejudice, or confusing the issues, or misleading the jury.

• Necessitating an Undue Consumption of Time — Plaintiff will have to put on testimony on this collateral issue showing the lien is not contingent. Plaintiff will have to bring in a billing expert to establish that the standard is liens are not contingent and the client is ultimately responsible for payment.

• Confusing and Misleading — the defense attempt to portray to jurors that the lien is "contingent" on the outcome of the case, and therefore there exists a bias for the medical witness to give testimony that will ensure recovery, is incorrect. Medical liens are not contingent on the outcome of the case. The lien states that the debt is owed regardless of the outcome of the case. Win, lose, or draw, the patient is responsible for the debt.

• Substantial Danger of Undue Prejudice — there is a substantial danger of prejudice as the jury may buy into the false and misleading argument that the lien is contingent when it is not.

Reasonable and necessary treatment

Whether plaintiff treated on a lien basis is a collateral irrelevant issue. The real issue at trial concerning medical treatment is whether it was reasonable and necessary. CACI 3903A provides:

> To recover damages for past medical expenses, plaintiff must prove the reasonable cost of reasonably necessary medical care that he/she has received.

Hanif v. Housing Authority of Yolo County (1988) 200 Cal.App.3d 635, 640, states:

> [A] person injured by another's tortuous conduct is entitled to recover the reasonable value of medical care and services reasonably required and attributable to the tort.

Howell v. Hamilton Meats & Provisions, Inc., supra, is the seminal case on what medicals plaintiff is entitled to present and recover at trial. *Howell* holds:

> • Reasonable Value or Less-Contract Rate "[A] plaintiff may recover as economic damages no more than the reasonable value of medical services received and is not entitled to recover the reasonable value if his or her actual loss was less. California decisions have focused on 'reasonable value' in the context of limiting recovery to reasonable expenditures, not expanding recovery beyond the plaintiff's actual loss or liability to be recoverable, a medical expense must be both incurred and reasonable.

(*Id*. at 555.)

> • Health Insurance Contract Rate Limit: "[A]n injured plaintiff whose medical expenses are paid through private insurance may recover as economic damages no more than the amounts paid by the plaintiff or his or her insurer for the medical services received or still owing at the time of trial.

(*Id*. at 556.)

> • Collateral Source Rule Alive and Well: "[W]e in no way abrogate or modify the collateral source rule as it has been recognized in California; we merely conclude negotiated rate differential – the discount medical providers offer the insurer – is not a benefit provided to the plaintiff in compensation for his or her injuries and therefore does not come within the rule.

(*Id*. at 556.)

Ochoa v. Dorado (2014) 228 Cal.App.4th 120, is the most recent case on *Howell* related issues. In *Ochoa*, plaintiffs received treatment including surgery by orthopedist Dr. Michael Schiffman on a lien. Plaintiff identified Dr. Schiffman as a "non-retained" expert and did not do an expert witness declaration regarding expertise and expected testimony. Defendant's motion in limine to exclude Dr. Schiffman from testifying on reasonableness and necessity of medicals was granted.

Ochoa holds:

• Trial court was in error and a treating physician may give an "opinion as to the reasonable value of services that the treating physician either provided to the plaintiff or became familiar with independently of the litigation, assuming the treating physician is qualified to offer an expert opinion on reasonable value.

• Reaffirms *Howell* – That plaintiff is entitled to the "lesser of (1) the amount paid or incurred for past medical services and (2) the reasonable value of the services.

• Reaffirms *Pacific Gas and Electric Company v. G.W. Thomas Dravage Co*. (1968) 69 Cal.2d 33, 42 that "if the charges were paid, the testimony and documents are evidence that the charges were reasonable.

• Cases holding expenses incurred equals reasonable value are incorrect, e.g., *Malinson v. Black* (1948) 83 Cal.App.2d 375, *Guerra v. Balestrieri* (1954) 127 Cal.App.2d 511 and *Katiuzhinsky v. Perry* (2007) 152 Cal.App.4th 1288.

Health insurance, liens and mitigation

If the plaintiff has health insurance and chooses a lien provider instead of using a doctor approved through her health insurance there is the potential that the defense will argue the plaintiff failed to mitigate her damages by choosing to go with a lien doctor when the plaintiff was covered by insurance that would not have involved the plaintiff incurring a debt. The argument is that "something is not right with the arrangement" or the plaintiff is not mitigating her damages. How should Counsel counter this argument by the defense?

Plaintiff's counsel should either file a motion *in limine* or trial brief outlining the inapplicability of the duty to mitigate argument concerning who the plaintiff decides to use for her accident related medical needs.

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CACI 3930 Mitigation of Damages (Personal Injury) provides:

> If you decide defendant is responsible for the original harm, plaintiff is not entitled to recover damages for harm that defendant proves plaintiff could have avoided with reasonable efforts or expenditures.
>
> You should consider the reasonableness of plaintiff's efforts in light of the circumstances facing her at the time, including her ability to make the efforts or expenditures without undue risk or hardship.
>
> If plaintiff made reasonable efforts to avoid harm, then your award should include reasonable amounts that she spent for this purpose.

In *Christiansen v. Hollings* (1941) 44 Cal.App.2d 332, 346, it was held:

> The correct rule is that an injured person must use reasonable diligence in caring for his injuries. What is reasonable diligence depends upon all the facts and circumstances of each case. There is no hard and fast rule that the injured person must seek medical care of a particular type. Self-care may be reasonable under the circumstances, and the jury should be so instructed where that factor is relevant."

The court in *Valet de Oro Bank v. Gamboa* (1994) 26 Cal.App.4th 1686, 1691, held:

> [T]he rule of mitigation of damages has no application where its effect would be to require the innocent party to sacrifice and surrender important valuable rights.

According to *LeMons v. Regents of University of California,* (1978) 21 Cal.3d 869,

> [T]he mitigation rule was concerned with a lack of due care after the injury.

Thus, *the mitigation of damages rule does not apply when it comes to a choice of doctor*, namely to treat with a doctor on a lien.

In summary:

- The mitigation instruction applies to "lack of care" after an injury.
- Plaintiff is free to choose the best doctor and is not limited to a doctor within network of their health insurance.
- Allowing the defense to argue to the jury that plaintiff's failure to use health insurance is failure to mitigate damages flies in the face of the collateral source rule, as the only way to prove mitigation under this circumstance is to bring out health insurance which is still inadmissible under the *Howell* decision.
- Plaintiff has a right to expect the at fault tortfeasor to cover all damages without having to touch plaintiff's own insurance and face co-pays and deductibles.

If plaintiff loses the motion in limine

How should plaintiff's counsel handle the medical lien issue at trial assuming the motion in limine is lost:

- Jury Selection – During voir dire when members of the panel state they have been involved in an accident and have made a claim, there will most likely be a potential juror that has treated on a lien. Establish they understood they were responsible for the bill regardless of the outcome, but the lien allowed them to receive necessary treatment and not go out of pocket for an accident that was not their fault. Establish in the minds of the panel that it is commonplace for an accident victim to treat on a lien.
- Bring out on Direct – If the evidence of the medical lien is coming into the evidence, the jury should not hear about it first from defense counsel. That makes it look as if plaintiff is trying to "hide something." Establish a good basis for the lien doctor, for example, the plaintiff researched shoulder surgeons and wanted to go with best possible shoulder surgeon who happened to be outside their insurance network. If plaintiff had Medi-Cal, Medicare or an HMO, establish that not many of the top doctors accept these forms of coverage.
- Establish plaintiff wanted the tortfeasor to cover the losses and not use their own insurance.
- Establish that plaintiff could not afford the deductibles and co-pays.
- Establish in deposition that the defense doctor treats patients on a lien, that it is commonplace and the defense doctor sees nothing wrong with a patient treating on a lien basis.

Statutory liens

• Workers' Compensation Liens: *Sanchez v. Brooke,* (2012) 204 Cal.App.4th 126, established that *Howell* applies to medical bills paid through the Workers' Compensation system. Thus, what was paid and accepted though the Workers' Compensation system sets the cap on the amount of the bill which is recoverable. Where the client is covered by workers compensation, it is not advisable to treat on a lien outside the Workers' Compensation system.

There will necessarily be some medicals coming into the evidence under the Workers' Compensation payment schedule and if the lien doctor's charges vary much from workers' comp charges, it will look bad to the jury. The jury may have a harder time believing the medicals are reasonable and necessary if they are outside the Workers' Compensation system, where the treatment is covered regardless of fault. If plaintiff does not make a full financial recovery, the lien medicals will still be owed whereas under the Workers' Compensation system all meds would have been covered. This is putting the client at risk for potentially unrecovered medical bills.

• Medi-Cal and Medicare

Under Medi-Cal and Medicare, plaintiff is typically only able to collect pennies on the dollar for these covered medicals. (*Hanif v. Housing Authority,* (1988) 200 Cal.App.3d 635; *Luttrell v. Island Pacific Supermarkets, Inc.,* (2013) 215 Cal.App.4th 196.) Counsel may want to consider waiving past medicals covered by Medi-Cal or Medicare, especially if plaintiff needs future surgery. Small past medicals will often anchor the future surgery award as well as pain and suffering damages.

Medical liens and factoring companies

Katiuzhinsky v. Perry (2007) 152 Cal.App.4th 1288, held that where plaintiff signs a lien and a factoring company buys the lien for a lesser amount than the

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full amount of the debt owed, plaintiff is still responsible for the full bill and the full bill can be admitted into evidence as long as reasonable and necessary. *Howell* left *Katiuzhinsky* intact. *Ochoa*, however, expressly declines to follow *Katiuzhinsky*, finding that the evidence of the lien invoices was not admissible.

Children's Hospital Central California v. Blue Cross of California (2014) 226 Cal.App.4th 1260, involves a dispute over the reasonable value of post-stabilization emergency medical services provided by the hospital to Medi-Cal managed care plan holders during a ten month period when there was no contract that covered those beneficiaries. Blue Cross paid $4.2 million for $10.8 million of billed services based on Medi-Cal rates paid by the government. The trial court denied a motion by Blue Cross for discovery on amounts the Hospital typically accepts as payment in full.

The jury awarded the full billed amount. Blue Cross of California appealed and the Court of Appeal reversed and held Blue Cross should have been allowed discovery on amounts usually accepted by the Hospital. This case is fodder for the defense to argue that what a medical provider on a lien typically accepts for their billed lien charges versus what they bill is discoverable. The plaintiff should argue that *Children's Hospital* is clearly distinguishable to the personal injury setting as it involves specific statutes which are unique to the relationship between medical service providers and health insurance providers under the Medi-Cal program; that it would take a Herculean effort for a lien doctor to go back over every patient's file to figure out what was billed and what was paid, and that to do so also involves HIPPA privacy concerns.

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[*Editor's note: This essay was originally presented at the CAALA Annual Convention in 2014*.]