

IN THE SUPREME COURT OF MISSOURI

Appeal No. SC 92700

Alice Roberts, et al.,

Appellants,

vs.

BJC Health System d/b/a BJC Healthcare, et al.,

Respondents.

**SUBSTITUTE BRIEF OF APPELLANTS
ALICE ROBERTS, KEVIN HALES, AND TIM AND CHRISTY MILLSAP**

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JURISDICTIONAL STATEMENT

This is an appeal from a final judgment of the Twenty-Second Judicial Circuit Court located in the City of St. Louis, Missouri, wherein the trial court entered summary judgment in favor of Respondent health care providers and against individual Appellants who represent a putative class, on a claim for damages resulting from Respondents' charging for services not performed and/or fraudulently or negligently overcharging for care and services rendered and products and facilities provided, and thereby misleading Appellants and others into paying for, approving, and/or accepting liability for improper and false charges.

The trial court entered its judgment on March 16, 2011, which became final on April 15, 2011. Appellants timely filed their Notice of Appeal on April 21, 2011.

On May 15, 2012, the Court of Appeals, Eastern District, affirmed the circuit court and issued a Memorandum Supplementing Order Affirming Judgment Pursuant to Rule 84.16(b). On May 30, 2012, Appellants filed with the Court of Appeals an Application for Transfer to the Supreme Court, which the Court of Appeals denied on June 28, 2012. Subsequently, on July 13, 2012, Appellants filed in the Supreme Court an Application for Transfer to the Supreme Court, which this Court sustained on August 14, 2012.

STATEMENT OF FACTS

Factual History

Appellant Alice Roberts was a patient of Dr. Richard Coin (“Dr. Coin”) and his wholly-owned corporation, Reconstructive and Microsurgery Associates, Inc. (“RMA”). Dr. Coin treated Ms. Roberts for work-related carpal tunnel syndrome. Five of those treatments took place at St. John’s Mercy Medical Center (“St. John’s”), a member of the Sisters of Mercy Health System (“SOM”). Prior to the treatments at St. John’s, Ms. Roberts and St. John’s executed a contract (Appendix (“App.”) A10-A11). This contract imposed upon Ms. Roberts personal liability for the costs of the medical services to be rendered to her by St. John’s. Ms. Roberts also agreed that St. John’s could send the bills directly to any insurer and that the insurer could send payment directly to St. John’s. App. A10-A11. If the insurer did not pay, however, responsibility for payment remained upon Ms. Roberts. St. John’s position regarding Ms. Roberts’ ultimate financial responsibility was reinforced each and every time St. John’s prepared an Itemized Statement of Account billing statement for Ms. Roberts. Those statements noted:

NOTE: AMOUNTS INDICATED TO BE PAID BY THIRD
PARTIES ARE ESTIMATED BY THE HOSPITAL.
HOWEVER, THE PATIENT AND/OR RESPONSIBLE
PARTY HAVE PERSONALLY GUARANTEED
PAYMENT AND ARE RESPONSIBLE FOR THE TOTAL
CHARGES ON THIS STATEMENT.

App. A13-A14.

Appellant Kevin Hales was also a patient of Dr. Coin and RMA. Mr. Hales suffered a work-related injury when a power saw cut through his index and middle fingers on his left hand. Dr. Coin and RMA treated Mr. Hales five times at St. John's, plus one time at Missouri Baptist Medical Center ("Missouri Baptist"), a member of the BJC Health System ("BJC"). Like Ms. Roberts, Mr. Hales also signed a contract with St. John's, making him personally liable for the costs of medical services he received there while allowing the hospital to bill directly to, and collect directly from, any applicable insurer. App. A8. Like Ms. Roberts, St. John's sent to Mr. Hales billing statements reminding him that he "personally guaranteed payment" and bore ultimate responsibility for payment of the charges. App. A15-A16. With respect to his treatment at Missouri Baptist, Mr. Hales signed a contract similar to the one he had executed with St. John's. App. A9.

Brittany Millsap, the minor daughter of Appellants Tim and Christy Millsap, suffered a facial laceration during an accidental fall. Dr. Coin and RMA treated Brittany in the St. John's emergency room. Brittany's parents agreed to be personally liable for the costs of the medical services provided to her at St. John's, pursuant to a contract they entered into with the hospital, virtually identical to those executed by Ms. Roberts and Mr. Hales. App. A12. As Ms. Roberts and Mr. Hales had done, the Millsaps also allowed the hospital to bill directly to, and receive payment directly from, the Millsaps' insurance carrier. App. A12.

During the time period he was treating Ms. Roberts, Mr. Hales and Brittany, Dr. Coin (along with RMA) was engaged in a criminal scheme to overcharge for medical

services through procedures known as “upcoding” and other “miscoding.”¹ Specifically, beginning as early as December 1993, and continuing up until at least October 2002, RMA, by and through Dr. Coin, utilized these procedures in order to charge for care and services not performed at all and/or to misrepresent that Dr. Coin had provided more expensive care and services, or utilized more expensive procedures than had actually

¹ The healthcare provider industry, which includes all Respondents in this case, utilizes a system referred to as “coding,” pursuant to which it refers to healthcare procedures, services, products and facilities by standard codes, for purposes of recordkeeping and billing. (LF 24). RMA’s miscoding consisted of unbundling, upcoding and fabrication of procedures. (LF 230). Unbundling is coding separately for a procedure that is included in the global code. (LF 237, 1215). Upcoding is billing for a more expensive procedure than was performed. (LF 237-8, 1215). Fabrication is billing for procedures that were not performed. (LF 227).

occurred.² This conduct of Dr. Coin and RMA misled patients into paying for, approving, and/or accepting liability for improper and false charges. (LF 25).³

In October 2007, RMA and Dr. Coin pleaded guilty to healthcare fraud and making a false demand, respectively, in the United States District Court for the Eastern District of Missouri (LF 24, 1260; SLF 2-3). Dr. Coin further admitted false statements that he had made in operative reporting, knowing that he had not performed some of the procedures he listed in the operative reports. (SLF 3). Through Dr. Coin, RMA admitted in detail how it and its agents falsely and fraudulently stated in operative reports and other treatment notes that surgical procedures had been performed when they knew some

² By way of example, according to St. John's own records, Brittany Millsap, age 8, actually suffered a simple 1-centimeter laceration to her right eyebrow. Dr. Coin and RMA, however, falsely coded Brittany's injury as a complex, 2.2-centimeters-long laceration to her eyelid. Dr. Coin subsequently claimed to have extended the cut to 2.9-centimeters during the course of his treatment. All of these coding differences caused Respondents to charge additional and improper amounts for the treatment of Brittany's wound. (LF 45-46).

³ In some instances in this Brief, Appellants cite to their Petition in support of certain statements of fact. The circuit court, by agreement of the parties, considered only the issues of standing and injury-in-fact, and limited discovery to those matters. (SLF 82-83). The procedural history of this case dictates this method as only one party, BJC, filed an Answer in the proceedings below.

of the services had not been provided. The non-rendered services included synovectomies, tenosynovectomies, Z-plasties, fasciocutaneous flaps, and repairs of tendons, ligaments, nerves and arteries. (SLF 3).

During the same period that Dr. Coin and RMA were engaged in their criminal scheme, St. John's, SOM, Missouri Baptist and BJC granted privileges to Dr. Coin and/or to RMA, and allowed them to utilize their respective facilities in conjunction with RMA's scheme. (LF 25, 40). On some occasions these Respondents specifically endorsed RMA and Coin and referred patients to RMA and Coin. (LF 25). These activities caused and contributed to the charging for services not performed and/or the overcharging of patients by RMA. (LF 25). Moreover, the hospital and health system Respondents themselves directly profited from the RMA scheme by utilizing billing systems which based their billings upon RMA's descriptions and miscoding, which in turn caused Respondents to overcharge as well. (LF 25). Respondents knew or should have known that RMA's miscoding directly contradicted the hospital Respondents' own records. (LF 25). The health system Respondents promoted their hospitals by holding out to the public that they were directly involved in the oversight and control of the quality and costs of care. (LF 30-31, 33-34).

Appellants' expert witness, Raymond V. Janevicius, M.D., testified in his deposition that, upon reviewing the records for Ms. Roberts' treatment, he found miscoding in the form of upcoding and unbundling of procedures. (LF 230). He further testified that his review of Mr. Hales' treatment records revealed miscoding in the form of upcoding and fabrication of medical procedures. (LF 230). And, as to Brittany's

treatment, the records demonstrated miscoding in the form of upcoding and unbundling of procedures. (LF 230). Dr. Janevicius definitively stated that the Respondents miscoded (including unbundling, upcoding and fabrication of procedures) and that this miscoding resulted in improper medical charges to the Appellants, although Dr. Janevicius did not render an opinion as to the dollar amounts of the fraudulent charges. (LF 230-31, 236-39).

Appellants' Suit and Its Procedural History

On October 12, 2004, Appellants filed in the circuit court a class action Petition containing twenty-six counts sounding in both contract and tort. (LF 28-29).⁴ The petition alleges that RMA overcharged for medical services and that the other Respondents used RMA's fraudulent billings to overcharge for the services they provided as well. The Petition seeks class action status on behalf of all natural persons who were overcharged by any of the Respondents as a result of the scheme of RMA and/or Dr. Coin. (LF 48).

⁴ Appellants subsequently filed a First Amended Class Action Petition. (SLF 1-81). The circuit court never expressly granted leave for the filing of the amendment. (LF 16-17). Nevertheless, two of the Respondents, and the Circuit Court, treated the First Amended Petition as the operative pleading. (LF 251, 379, 1214). No material differences exist between the causes of action set forth in the original Petition and those alleged in the First Amended Class Action Petition. (LF 23-81, 1224, 1228; SLF 1-81).

Respondents moved to dismiss the Petition and/or for summary judgment. (LF 124-806). Respondents claimed that Appellants lacked standing to sue because they had not paid any of the alleged overcharges themselves, but instead had had those payments made for them by workers' compensation insurance or by private health insurance. (LF 124-131, 251-253, 379-381, 594-600, 740-753).

In addition, St. John's removed the case to federal court, asserting federal subject matter jurisdiction and preemption under ERISA. (LF 385, 577-79). The federal court subsequently held that Appellants failed to establish Article III standing and, after a detour to the Eighth Circuit Court of Appeals, remanded the case to the circuit court. (LF 22, 385, 582-92, 593).

Upon remand, the circuit court conducted a status conference on November 18, 2008. On that date the court entered a scheduling order stating, in part, that "the parties shall pursue discovery limited to the issue of standing and named [Appellants'] injury in fact. Within 30 days of the conclusion of the aforesaid discovery, [Respondents] shall file their motions for summary judgment regarding standing and injury in fact issues." (LF 12; SLF 82-83). The court subsequently extended the time frames set forth in the scheduling order. (LF 10, 125, 132, 807; SLF 84-85).

At the close of the designated period for limited discovery, four of the Respondents each filed a motion for summary judgment, together with a supporting statement of uncontroverted material facts. (LF 124-739). SOM filed a motion to

dismiss.⁵ (LF 740 – 806). Appellants filed responses, including a statement of additional material facts (LF 807 – 930); Respondents filed responses thereto, (LF 931-973, 1087-1179, SLF 86-97); and Appellants filed their sur-reply and responses. (LF 974 -1086, 1180-1213).

On September 9, 2010, the circuit court entered a Memorandum and Order granting in part and denying in part Respondents’ motions for summary judgment and motion to dismiss. (LF 1214 – 1223). All parties moved for reconsideration and/or clarification. (LF 1224-1258). On December 23, 2010, the Court vacated its September 9th Order. (LF 1259).

Upon reconsideration, on March 16, 2011, the Court entered its Memorandum, Order and Judgment (the “Judgment”) (LF 1260 – 1266), from which Appellants appeal. In the Judgment, the circuit court did not agree with Respondents’ contention that Appellants lacked standing to pursue their claims. (LF 1265). The circuit court, however, granted summary judgment in favor of Respondents, based on “a failure of proof of damages.” (LF 1265). As a result, the circuit court entered judgment in favor of all

⁵ SOM purported to support its Motion to Dismiss with a joint statement of uncontroverted material facts by SOM and St. John’s. (LF 740-806). The circuit court and the parties appear to have, appropriately, analyzed SOM’s motion no differently from a motion for summary judgment. *See* Mo. R. Civ. P. 55.27(a) (motion to dismiss for failure to state a claim shall be treated as a motion for summary judgment if it presents matters outside the pleadings).

Respondents and against Appellants on all of Appellants' claims and dismissed with prejudice Appellants' Petition in its entirety. (LF 1266).

This appeal followed.

POINT RELIED ON

The trial court erred when it granted summary judgment to the Respondents and dismissed Appellants' Petition because the Appellants had standing to bring the claims alleged therein and made a sufficient showing that they sustained damages in that the contracts between Appellants and Respondents obligated Appellants to pay Respondents for medical services rendered by Respondents to Appellants, and the payment of Respondents' bills by third-party insurers on Appellants' behalf does not, as a matter of law, negate the Appellants' showing of damages.

Berra v. Danter, 299 S.W.3d 690, 697 (Mo. Ct. App. 2009)

Douthet v. State Farm Mut. Auto. Ins. Co., 546 S.W.2d 156 (Mo. banc 1977)

Keisker v. Farmer, 90 S.W.3d 71, 74 (Mo. banc 2002)

Washington v. Barnes Hospital, 897 S.W.2d 611 (Mo. banc 1995)

ARGUMENT

The trial court erred when it granted summary judgment to the Respondents and dismissed Appellants' Petition because the Appellants had standing to bring the claims alleged therein and made a sufficient showing that they sustained damages in that the contracts between Appellants and Respondents obligated Appellants to pay Respondents for medical services rendered by Respondents to Appellants, and the payment of Respondents' bills by third-party insurers on Appellants' behalf does not, as a matter of law, negate the Appellants' showing of damages.

A. Standard of Review

When considering an appeal from summary judgment, appellate review is essentially de novo. The court reviews the record in the light most favorable to the party against whom judgment was entered. *ITT Commercial Finance Corp. v. Mid-America Marine Supply Corp.*, 854 S.W.2d 371, 376 (Mo. banc 1993). The court accords the non-movant the benefit of all reasonable inferences from the record. *Id.* The criteria on appeal for testing the propriety of summary judgment are the same as those that should be employed by the trial court to determine the propriety of sustaining the motion initially.

The propriety of summary judgment is wholly an issue of law. *Id.* As the trial court's judgment is founded on the record submitted and the law, the appellate court need not defer to the trial court's order granting summary judgment. *Huber v. Wells Fargo Home Mortg., Inc.*, 248 S.W.3d 611, 613 (Mo. 2008).

B. Discussion

1. The Appellants have standing and constitute the real parties in interest.

This Court should have little difficulty rejecting the position, advanced by Respondents in the circuit court, that Appellants lack standing to pursue their claims because they themselves did not pay any money to Respondents. Interestingly, the circuit court did not accept Respondents' contention that Appellants lacked standing. *See* Judgment at p. 6. (LF 1265). Essentially, standing means that a party seeking relief must have some personal interest at stake in the dispute; alleging a threatened or actual injury caused by a challenged action satisfies this personal interest requirement. *See Adams v. Cossa*, 294 S.W.3d 101, 104 (Mo. Ct. App. 2009); *Crumbaker v. Zadow*, 151 S.W.3d 94, 96 (Mo. Ct. App. 2004). In the case at bar, Appellants demonstrated a "personal stake" as they were victims of a scheme to improperly charge for medical services.

Payment by the Appellants' insurers of overcharges does not deprive Appellants of their status as real parties in interest. The party with the bare legal title to a claim is the real party in interest. *See* Mo. Rev. Stat. § 507.010 (2009) (prosecution in name of real party in interest); Mo. Sup. Ct. R. 52.01. An insurer who pays a loss does not become the real party in interest unless the insured has assigned the underlying claim to the insurer. *Protection Sprinkler Co. v. Lou Charno Studio*, 888 S.W.2d 422, 424 (Mo. Ct. App. 1994); *Klein v. General Elec. Co.*, 714 S.W.2d 896, 902-03 (Mo. Ct. App. 1986). When an insured does not assign his or her claim, the insured retains title to the action. Here, the record provides no indication that any of the Appellants have assigned their claims.

Respondents' position fails to recognize the crucial distinction, under Missouri law, between assignment and subrogation. In Missouri, as a matter of law, the insurer is *not* the real party in interest; rather (absent an assignment), the insurer is instead subrogated to the rights of the injured person against the wrongdoer or others who are primarily responsible for the wrong or default. "In subrogation, the insured retains legal title to the claim. By paying the insured, the insurer has a right to subrogation. *The exclusive right to pursue the tortfeasor remains with the insured.*" *Keisker v. Farmer*, 90 S.W.3d 71, 74 (Mo. banc 2002) (emphasis added) (citations omitted) (where property insurer intervened in insured's negligence action against drivers for damage to its business as result of drivers' accident, Court held insurer had right of subrogation; thus, the insured retained exclusive right to pursue the tortfeasor; insured would hold proceeds to extent of insurer's payment to insured for insurer's benefit).⁶

Consequently, in this case, Appellants have a legally cognizable interest in the subject matter of the suit, and they have suffered an injury. Appellants became liable for Respondents' charges for services, and their rights – not those of the third party insurers – have been violated. Appellants are the real parties in interest and have standing to bring their claims.

⁶ The situation differs somewhat in the workers' compensation context, but the key point holds true: the employee is the primary owner of the claim against the third party. *See infra* at pp. 30-32.

2. Appellants suffered damages from Respondent's improper charging for the medical services provided to Appellants.

a. Appellants themselves incurred the overcharges.

This Court should reverse the circuit court's judgment in this case because the circuit court's judgment rested upon the completely erroneous belief that Appellants could not possibly have sustained damages if Appellants did not pay, out-of-pocket, the inflated bills submitted by the Respondents.

As an initial matter, the record in this case contains evidence that establishes that Respondents did, in fact, overcharge Appellants. Specifically, Appellants' expert witness testified that Respondents' miscoding of medical procedures (including unbundling, upcoding and fabrication) resulted in improper, inappropriate and excessive charges to Appellants. (LF 230-39). The expert noted that he had not calculated, in dollars and cents, the amounts of the overcharges, but he was unequivocal in his assessment that Respondents had, in fact, improperly charged Appellants. (LF 230-31, 237).

Further, the record herein establishes that Respondents considered Appellants legally responsible for payment of the charges. Prior to rendering medical treatment, the Respondents required the Appellants to enter into contractual agreements pursuant to which Appellants agreed to accept primary responsibility for payment of the Respondents' bills. (LF 989-993; App. A8-A12). Nor did at least one of the Respondents miss any opportunities to remind Appellants of their ultimate legal responsibility for the charges. On multiple occasions Respondent St. John's sent to Appellants Roberts and Hales a statement of the charges which these Appellants had

incurred; on each of these statements Respondent included the words, “The patient and/or responsible party have personally guaranteed payment and are responsible for the total charges on this statement.” (LF 776-98).

The fact that insurance companies paid the bills in no way negates the fact that it was Appellants who bore ultimate legal responsibility for the charges and who, therefore, were the ones who incurred the charges. Contrary to the position taken by the circuit court, Missouri courts have consistently rejected the notion that a litigant “incurs” medical bills only to the extent of the dollar amount he or she actually pays. *See, e.g., Berra v. Danter*, 299 S.W.3d 690, 697 (Mo. Ct. App. 2009) (noting that “incur” means to “become liable for or subject to” and that the word is a synonym of “accrue”; court commented that “[a]ccruing or incurring . . . is not the same as paying”). *See also Wheeler ex rel. Wheeler v. Phenix*, 335 S.W.3d 504, 517 (Mo. Ct. App. 2011) (in valuing a plaintiff’s medical treatment, a court may hear evidence that includes “medical bills incurred by a party” as distinguished from amounts actually paid) (citing *Berra*); *Brown v. Van Noy*, 879 S.W. 2d 667, 676 (Mo. Ct. App. 1994) (rejecting defendant’s contention that expenses paid or “written off” as part of Medicare coverage should not be considered medical charges incurred by a plaintiff to be considered when determining plaintiff’s damages; “[i]t is immaterial whether plaintiff paid [the medical expenses] directly or indirectly by his medical insurance. It sufficed that plaintiff showed the amount *charged* or paid”) (emphasis in original) (internal citation omitted).

Moreover, Missouri courts have relied upon the distinction between “incurred” and “paid” in contexts other than medical bills. *See, e.g., Litton v. Kornbrust*, 85 S.W.3d

110 (Mo. Ct. App. 2002) (party can obtain reimbursement for deposition costs even if insurer actually paid the charges); *Next Day Motor Freight, Inc. v. Hirst*, 950 S.W.2d 676 (Mo. Ct. App. 1997) (party can recover from other party attorneys' fees without showing that those fees have actually been paid if party seeking recovery can show that those fees were incurred); *Burwick v. Wood*, 959 S.W.2d 951, 952 (Mo. Ct. App. 1998) (construing Mo. Rev. Stat. § 492.590 to allow recovery of deposition costs incurred by a party without showing that the party had actually paid those costs).

In the case at bar, Appellants incurred the medical charges at issue because Appellants bore ultimate liability and responsibility for the payment of the charges.

- b. The circuit court disregarded the Collateral Source Rule when it erroneously determined that Appellants had not sustained damages as a result of Respondents' overcharging them for medical services.**

i. The Rule and its Rationale

In light of the collateral source rule, the trial court's judgment cannot stand. "Under the collateral source rule or doctrine . . . which is a well-established rule in the law of damages, a wrongdoer is not entitled to have the damages to which he is liable reduced by proving that plaintiff has received or will receive compensation or indemnity for the loss from a collateral source, wholly independent of him, or, stated more succinctly, the wrongdoer may not be benefitted by collateral payments made to the person he has wronged." *Collier v. Roth*, 434 S.W.2d 502, 506-07 (Mo. 1968) (internal

quotation marks and citations omitted). *See also Washington v. Barnes Hospital*, 897 S.W.2d 611 (Mo. banc 1995) (discussed *infra* at pp. 21-22).

The collateral source rule most often arises in personal injury litigation. In that situation, a plaintiff is injured by the tortious conduct of a defendant, and some or all of the plaintiff's medical bills are paid by medical insurance procured by or for the plaintiff. The collateral source rule prevents the defendant tortfeasor from (1) reducing the damages he or she owes by the amount of the insurance payments received by the plaintiff, or (2) introducing at trial evidence of those payments. *See Iseminger v. Holden*, 544 S.W.2d 550, 552 (Mo. 1976).

Missouri courts, however, do not limit application of the collateral source rule to the personal injury context. "Though more commonly employed in tort cases, the collateral source rule also applies to contract actions." *Protection Sprinkler Co. v. Lou Charno Studio, Inc.*, 888 S.W.2d at 424. In *Protection Sprinkler*, two parties settled a suit and agreed that one (Lou Charno Studio) would indemnify the other (Protection Sprinkler) in the event of a suit against Protection Sprinkler. *Id.* Sure enough, a third party sued Protection Sprinkler, which incurred legal fees defending itself until the suit was ultimately dismissed. Protection Sprinkler sued Lou Charno and sought reimbursement of the legal fees it incurred in defending itself against the third party's suit. Lou Charno tried to avoid liability by arguing that Protection Sprinkler actually incurred no expenses because its insurance carrier had paid all the costs of the defense. The Court of Appeals rejected the argument, based upon the collateral source rule. *Id.*

Similarly, in *Fust v. Francois*, 913 S.W.2d 38 (Mo. Ct. App. 1995), Francois had previously sued the Fusts, the owners of neighboring property, alleging trespass, defamation and harassment. *Fust*, 913 S.W.2d at 43. The court ultimately dismissed the suit. *Id.* The Fusts then sued Francois, alleging malicious prosecution; the Fusts prevailed, and Francois appealed. *Id.* Among other things, Francois argued on appeal that the trial court erred in precluding him from introducing evidence that the Fusts themselves did not pay the costs for the attorney to defend them in the original suit, as the entire attorneys' fees was paid by the Fusts' title insurer. *Id.* at 46. Francois argued that, because the Fusts did not pay any money out of their own pocket, they did not sustain any damage. *Id.* at 47. The Court of Appeals affirmed the trial court. The Court stated, "[T]here was testimony concerning the services of the law firm [in the first action] and the amount of those services. Such testimony is sufficient evidence of damages. Whether the Fusts were the ones who in fact paid the law firm directly for the services is irrelevant." *Id.*

The collateral source rule expresses a policy judgment in favor of encouraging citizens to purchase and maintain insurance for personal injuries and for other eventualities. Courts consider insurance a form of investment, the benefits of which become payable without respect to any other possible source of funds. See "*Collateral Source Rule*," 77 A.L.R.3d 415 (2009). See also, *In re Lithotripsy Antitrust Litigation*, No. 98C8394, 2000 WL 765086 (N.D. Ill.) (not reported in F.Supp.2d (2000)) (granting motion for final approval of class action settlement and for joint award of attorneys' fees and expenses; defendants maintained class members suffered no damages because most

were covered by health insurance; Court rejected defendants' contention as it conflicted with the collateral source rule). Most courts⁷ and commentators⁸ characterize the

⁷ See, e.g., *Leitinger v. DBart Inc.*, 736 N.W.2d 1 (Wis. 2007) (collateral source rule began as a substantive rule of damages, but has since taken on an evidentiary character); *Johnson v. Dallas County*, 195 S.W.3d 853, 855 (Tex. App. – Dallas 2006) (dual nature of the collateral source rule is recognized and explained: substantive component is a rule of damages barring a defendant from reducing the plaintiff's compensatory award by the amount the plaintiff received from the collateral source; evidentiary component bars admission of evidence of existence of the collateral source or the receipt of benefits); *Wills v. Foster*, 892 N.E.2d 1018, 1022-23 (Ill. 2008) (recognizing that Illinois Supreme Court has held the collateral source rule has both evidentiary and substantive components); *Ex parte Barnett*, 978 S.2d 729, 737 (Ala. 2007) (court rejects argument that the collateral-source rule is merely a rule of evidence); *Schwartz v. Hasty*, 175 S.W.3d 621, 629 (Ky. App. 2005) (collateral source rule has two aspects: evidentiary and substantive; discusses evidentiary consequence of rule's substantive aspect); *Arambula v. Wells*, 72 Cal. App. 4th 1006, 1015 (1999) (collateral source rule operates both as a substantive rule of damages and rule of evidence); *Klosterman v. Fussner*, 651 N.E.2d 64, 67 (Oh. App. 2d 1994) (where rule applies, it serves both substantive and evidentiary purposes).

collateral source rule as functioning both as part of the substantive law of damages and as a rule of evidence.

In *Washington v. Barnes*, this Court's review of the numerous rationales used to justify the application of the collateral source rule is useful as the situation at bar is clearly covered:

Some courts state that plaintiffs who contract for insurance or other benefits with funds they could have used for other purposes are entitled to the benefit of their bargain. Some courts enforce the collateral source rule to punish the tortfeasor. Other courts opine that, if one party will receive a windfall, it should be the plaintiff. Additional rationales supporting the collateral source rule are: ...to avoid prejudice in the eyes of the jury because plaintiff was attempting to recover for an item for which he had not paid.

⁸ See, e.g., "Note: *The Collateral Source Rule And State-Provided Special Education And Therapy*," 75 Wash. U. Law Quarterly 697, 699 (Spring 1997) (discussion of *Washington v. Barnes Hospital*, 897 S.W.2d 611 (Mo. banc 1995)); *Restatement (Second) of Torts*, §920A (payments made to or benefits conferred on injured party from other sources are not credited against tortfeasor's liability, although they cover all or part of harm for which tortfeasor is liable).

Missouri courts have applied the collateral source rule to prevent defendants from informing juries of: insurance policies contracted for and paid for by plaintiffs; contracted for payments; and benefits from plaintiffs' employers (workers' compensation benefits); (disability pension benefits); (retirement benefits); (employer's medical plan); (sick leave).

Missouri courts have also found evidence regarding some governmental benefits to be subject to the collateral source rule. These include both governmental benefits contingent upon plaintiff's financial need or special status, such as medicare and medicaid....

897 S.W.2d at 619-20 (internal citations omitted).

Missouri courts have noted that the collateral source rule is a well established rule in the law of damages in that a wrongdoer is not entitled to have the damages to which he is liable reduced by proving that plaintiff has received or will receive compensation or indemnity for the loss from a collateral source, wholly independent of him, or, more straightforwardly, the wrongdoer may not be benefitted by collateral payments made to the person or on behalf of the person he has wronged. *See "The Collateral Source Rule in Missouri: Questioning the 'Double Recovery' Doctrine,"* 61 Mo. L. Rev. 633 (Summer 1996). *See, e.g., Buatte v. Schnuck Markets, Inc.*, 98 S.W.3d 569 (Mo. Ct. App.

2002) (collateral source rule is an exception to general rule that damages in tort should be compensatory only); *Lampe v. Taylor*, 338 S.W.3d 350, 360 (Mo. Ct. App. 2011) (same).

Early on, in a case which was remanded for a new trial on the limited issue of damages on the driver's liability for the injured party's medical expenses, this Court took the occasion to address this issue. *Kickham v. Carter*, 335 S.W.2d 83 (Mo. 1960).⁹ During trial, over objection of plaintiff, counsel was permitted to ask plaintiff whether he had Blue Cross and whether any of his bills were paid by Blue Cross. Appellant responded that all of his hospital bills had been paid by Blue Cross. On appeal, plaintiff contended that the trial court erred in admitting that evidence. *Id.* at 89-90.

The Court decided that plaintiff was entitled to recover reasonable hospital expenses incurred as a result of injuries resulting from the negligence of defendant even though such expenses were actually paid by Blue Cross pursuant to its contract with plaintiff and, hence, evidence of such payment was wholly immaterial in the action. "Upon principle there would appear to be no logical reason for defendant to receive the benefit of hospitalization payments (in the nature of insurance) made by an organization such as Blue Cross to which plaintiff had no doubt made contributions in accordance with a membership agreement." *Id.* at 90. Insurance payments received by the plaintiff cannot ordinarily be set up by the wrongdoer in mitigation of damages.

⁹ Subsequent case law refers to *Kickham* as the case in which the collateral source rule (a combination of different rationales) was established in Missouri. *See, e.g., Ford v. Gordon*, 990 S.W.2d 83, 85 (Mo. Ct. App. 1999).

Also instructive in this regard is the case of *Jim Toyne, Inc. v. Adams*, 916 S.W.2d 381 (Mo. Ct. App. 1996). Appellant insurance agency sued defendants, a law firm and one of its partners, for malicious prosecution of a lawsuit against the agency. The underlying lawsuit ended when the plaintiff dismissed it. The circuit court granted defendant's motion for directed verdict on the ground that Toyne had not established a submissible case. *Id.* at 382. The court concluded that because all of Toyne's expenses in defending the first lawsuit were paid by Toyne's insurer, Toyne did not establish that he was damaged. The circuit court noted the collateral source rule, but concluded it was "distinguishable from the normal collateral source rule" usually seen. *Id.* at 383.

The appellate court disagreed with the circuit court's belief that the collateral source rule did not apply. Rather, it held that the collateral source rule "provides that a wrongdoer is not entitled to have the damages to which he is liable reduced by proving that plaintiff has received or will receive compensation or indemnity for the loss from a collateral source." *Id.* at 383-84 (internal citations omitted). The *Toyne* court noted that Toyne had paid for the insurance coverage it received. "Moreover, if anyone should benefit from a 'windfall' in cases such as this, it should be the party wronged – not the tortfeasor." *Id.* at 384. The Court relied on precedent, stating that the courts of Missouri had followed the general rule that insurance payments received by the plaintiff cannot ordinarily be set up by the wrongdoer in mitigation of damages. *Id.*

Under the collateral source rule, whether the plaintiff has insurance coverage that will pay his or her damages is irrelevant. Missouri applies the collateral source rule in all cases. *See Smith v. Shaw*, 159 S.W.3d 830, 832 (Mo. 2005). This Court explained the

justification for the rule, which is an expression of the policy that a wrongdoer should not benefit from the expenditures made by the injured party in procuring insurance coverage. *See id.*; *Duckett v. Troester*, 996 S.W.2d 641, 648 (Mo. Ct. App. 1999), overruled on other grounds by *Spiece v. Garland*, 197 S.W.3d 594, 596 (Mo. 2006). *See also Corder v. Toys R Us – Delaware, Inc.*, 152 S.W.3d 310, 320 (Mo. Ct. App. 2004) (payments from sources such as medical insurance and Medicare qualify as collateral source payments that may not be introduced to the jury because plaintiffs who contract for insurance or other benefits with funds they could have used for other purposes are entitled to the benefit of their bargain); *Beck v. Edison Brothers, Inc.*, 657 S.W.2d 326 (Mo. Ct. App. 1983) (collateral source rule precludes evidence of payments received by injured employee from employer’s medical plan; although employee herself, unlike other employees, did not contribute to the plan, that plan nevertheless was an employment benefit subject to collateral source rule).

Here, contrary to the general rule, the circuit court used the collateral sources, *i.e.*, the insurers’ payment of medical bills on behalf of Appellants, to preclude Appellants’ claim of damages. In so doing, the circuit court erred and this Court should reverse.

ii. The Collateral Source Rule applies with equal force to workers’ compensation payments made to or on behalf of the plaintiff.

The fact that, in the case at bar, some of the improper charges were paid by workers’ compensation carriers by no means changes the result. It is well-settled in Missouri that evidence of payments made to a plaintiff under the Workers’ Compensation

Act are not ordinarily admissible in an action for that injury against a third party as a defense to the tort action or for the purpose of mitigating the damages recoverable.

Womack v. Crescent Metal Products, Inc., 539 S.W.2d 481, 483-84 (Mo. Ct. App. 1976).

Since *Womack*, Missouri courts' analysis of the reasoning to bar evidence of workers' compensation payments made to plaintiffs and/or medical providers followed a similar trajectory as the reasoning for disallowing evidence of private insurance payments in aid of defendant-tortfeasors in the non-workers' compensation context.

In *Douthet v. State Farm Mut. Auto. Ins. Co.*, 546 S.W.2d 156 (Mo. banc 1977), the trial court denied defendant's request to reduce plaintiff's recovery by the amount paid by a workers' compensation carrier to plaintiff for compensation and medical expenses incurred as a result of injuries plaintiff received in an automobile accident. In affirming the circuit court, this Court reasoned that defendant did not create or pay for, and was not the source of, the workers' compensation payments received by plaintiff. And, were defendant allowed credit for same, it would receive a windfall in that its coverage would be reduced despite the public policy expressed in the Missouri workers' compensation statute. "In such a situation, if there is to be a windfall, it should go to the injured person rather than to insurer." *Id.* at 160. See also *Kenniston v. McCarthy*, 858 S.W.2d 268 (Mo. Ct. App. 1993) (evidence that plaintiff received indemnity or compensation for an injury or loss from workers' compensation is ordinarily inadmissible as it is unrelated to liability or damages and may raise a false issue in the case); *Taylor v. Associated Electric Coop., Inc.*, 818 S.W.2d 669 (Mo. Ct. App. 1991) (certificate of workers' compensation insurance for third party contractor for which plaintiff worked

constituted evidence of collateral source of recovery and as such was inadmissible; an approved workers' compensation settlement was clearly inadmissible); *Curtis v. Consumer Supply Dist.*, No. 09-00971, 2011 WL 884055 (W.D. Mo. March 11, 2011) (grant of motion in limine for exclusion of evidence that plaintiff received compensation from workers' compensation or any other "collateral source").

Here, again, contrary to precedent and principle, the circuit court used the collateral sources, *i.e.*, medical expenses paid by workers' compensation carriers on behalf of Appellants Roberts and Hales, to preclude their claim of damages.

iii. Rule 74.04 precludes consideration of collateral source payments when adjudicating a motion for summary judgment.

The circuit court erred in concluding that Appellants sustained no damages when insurers paid Respondents' overcharges because the circuit court relied on inadmissible evidence to reach that conclusion. When considering a motion for summary judgment, a court can only consider evidence that would be admissible if offered at trial. *See generally* Mo. R. Civ. P. 74.04(e). *See also Johnson v. Jadico Inc.*, 155 S.W.3d 99, 101 (Mo. Ct. App. 2005) (where motion was supported by legal conclusions contained in an affidavit, grant of motion for summary judgment reversed); *Blunt v. Gillette*, 124 S.W.3d 502 (Mo. Ct. App. 2004) (where motion was supported by uncertified court records, grant of motion for summary judgment reversed); *Partney v. Reed*, 889 S.W.2d 896 (Mo. Ct. App. 1994) (evidence inadmissible on grounds of relevance; hearsay statements that would not be admissible at trial are not competent to support a motion for summary

judgment); *Cooper v. Albacore Holdings, Inc.*, 204 S.W.3d 238, 245 (Mo. Ct. App. 2006) (hearsay statements cannot be considered in ruling on the propriety of summary judgment).

As set forth above, see *supra* at pp. 20-21, courts and commentators generally regard the Collateral Source Rule as both part of the substantive law of damages and as a rule of evidence. Even were this Court to consider the doctrine to be only a rule of evidence, however, that rule would preclude Respondents herein from introducing at trial evidence that insurance companies had paid the medical charges which Respondents billed to or in the name of Appellants. Since Respondents could not offer such evidence at trial, the circuit court should not have considered such payments when ruling upon Respondents' summary judgment motions. But the circuit court's determination that Appellants sustained no damage rests *entirely* upon those payments! This Court, therefore, should now reverse the circuit court's judgment granting Respondent's motions for summary judgment.

c. The fact that workers' compensation insurance paid some of the overcharges does not deprive Appellants Roberts and Hales of standing.

To the extent the circuit court based its decision upon its view that those Appellants (Ms. Roberts and Mr. Hales) whose medical bills were paid through the workers' compensation system cannot claim to have suffered damages because Respondents, by law, cannot bill them for medical services, *see* Judgment at p. 3 (LF 1262), the circuit court's position rests upon a misconstruction of workers' compensation

law. The circuit court cited, in support of its position, section 287.140.13 of the workers' compensation statute. A portion of that section does appear to state that a healthcare provider, other than one selected by the employee at his or her own expense, shall not bill or attempt to collect any fee for services rendered to an employee due to a work-related injury after the provider has received specified notice. *See* Mo. Rev. Stat. § 287.140.13(1). This subsection by no means yields the conclusion that Appellants herein sustained no damages when Respondents overcharged them based upon Dr. Coin's miscoding.

Most fundamentally, the circuit court's invocation of a subsection of the statute ignores other subsections of the very same statute, and betrays a lack of understanding of the workers' compensation system as a whole. When an employee suffers a workplace injury, the employee is supposed to inform his or her employer, who is in turn supposed to arrange for medical care for the employee. Mo. Rev. Stat. § 287.127.1(2). Section 287.140.13(1) provides that, once the health care provider receives proper notice that this particular patient suffered an injury that might be compensable under the workers' compensation system, a "stay" takes effect whereby the provider is not supposed to bill the patient for the services. The statutory "stay," however, does *not* result in an automatic determination that the employee has no liability to the medical provider to pay the charges for the care provided. If it is subsequently determined that the injury for which the patient was treated did not arise out of and occur within the scope of employment, *see, e.g., Johme v. St. John's Mercy Healthcare*, 366 S.W.3d 504 (Mo. banc 2012), the provider can then bill the employee. *See* Mo. Rev. Stat. 287.140.13(3)

("[w]hen an injury is found to be noncompensable under this chapter, the hospital, physician, or other healthcare provider shall be entitled to pursue the employee for the unpaid portion of the fee or other charges for authorized services provided to the employee"). The statute cited by the circuit court, therefore, simply fails to support the circuit's conclusion that Appellants sustained no damages when Respondents overcharged them for medical services.

Moreover, the actions of Respondent St. John's demonstrate that this Respondent believed it could send to its Workers' Compensation patients regular notices reminding them of their ultimate liability for the medical charges. As stated above, *see supra* at pp. 2-3, St. John's statements of account sent to Appellants Roberts and Hales bore a legend informing them that, if insurance failed to pay, then the patients themselves were responsible for payment of the bills.

In addition, Missouri law makes crystal clear that an employee who suffers a workplace injury retains the right to control any legal action against a third party who might have liability in connection with the injury, although the concept of subrogation may require the employee to hold in trust some of the amounts recovered from the third party that should be returned to the employer or the employer's workers' compensation carrier. *See* Mo. Rev. Stat. 287.150; *Ruediger v. Kallmeyer Bros. Service*, 501 S.W.2d 56, 59 (Mo. banc 1973) (based on Section 287.150(3), this Court devised a method of calculation (commonly referred to as "the Ruediger formula") to apportion recoveries between employer and employee after subtraction of expenses); *Kinney v. Schneider Nat. Carriers, Inc.*, 200 S.W.3d 607, 613-14 (Mo. Ct. App. 2006) (an employee who sues and

recovers damages from a third-party tortfeasor for injuries to the employee holds in trust the amount due to the employer so as to protect the employer's right of subrogation).

The right to bring the action against the third party, however, belongs firmly to the employee, and the circuit court's pronouncement of subrogation as "irrelevant" on the grounds that "[t]he insurers and employers have the claims," *see* Judgment at p. 5 (LF 1264), simply and utterly misstates Missouri law.

The claim against the third party tort-feasor is the claim of the employee. The interest of the employer in the claim "is something that is carved out of the injured employee's interest." It is "wholly derivative" from the right of the employee to proceed against the third party tort-feasor. "[W]hile the word subrogated is used in Section 287.150, ... it is indemnity, and not true subrogation, for which the act provides."

State ex rel. Missouri Highway and Transp. Comm'n v. Copeland, 820 S.W.2d 80, 84 (Mo. Ct. App. 1991) (internal citations omitted). Where an employee is not derelict in pursuing, against a third party, an action to recover damages for an injury for which the employee has received workers' compensation benefits, as between employer and employee, the employee has the right to manage and control the suit. *Id.* *See also Smith v. Siedhoff*, 209 S.W.2d 233, 239 (Mo. banc 1948) (neither the employer nor the insurance carrier is a necessary party in an action by an employee to recover against a

third party who injured the employee); *Butts v. Personnel Services*, 73 S.W.3d 825, 832 (Mo. Ct. App. 2002) (employee may sue third party without employer joining in the suit).

In the case at bar, Appellants incurred charges for medical services provided to them by Respondents. The charges for the medical care rendered to Appellants were inflated. Under the above-stated principles of Missouri law, Appellants are the ones who were improperly charged; Appellants are the ones who sustained damage; and Appellants are the ones who have the right, subject to subrogation, to pursue against the Respondents the legal claims resulting from Respondents' overcharges.

d. Appellants suffered ascertainable loss under the Missouri Merchandising Practices Act.

The circuit court erred when it determined that Appellants did not sustain damage under the Missouri Merchandising Practices Act ("MPA"). That statute allows recovery for false, fraudulent, or deceptive merchandising practices. Mo. Rev. Stat. § 407.010 *et seq.* The circuit court agreed that "there surely was deception, at least by the crooked doctor." Judgment at p. 4 (LF 1263). The court erroneously concluded, however, that Appellants here did not suffer an "ascertainable loss of money or property," *id.*, citing in support of its conclusion the Southern District's decision in *Freeman Health System v. Wass*, 124 S.W.3d 504 (Mo. Ct. App. 2004).

That case, however, does not support the circuit court's judgment herein. In that case Wass suffered a serious injury for which he received treatment from Freeman. Freeman sent him a bill, but neither Wass, nor anyone on his behalf, paid the charges. Freeman sued Wass to collect. Wass filed a class-action counterclaim, alleging that

Freeman violated the MPA by unfairly billing him and others over the preceding five-year period. The trial court dismissed Wass' claim, Wass appealed, and the court of appeals affirmed. That court stated that, under the MPA, a "private right of action is given only to one who purchases and suffers damage." *Wass*, 124 S.W.3d at 507 (internal citation omitted). The court, consulting a dictionary, understood "purchase" to mean "to obtain by paying money or its equivalent." *Id.* Wass did not pay money or its equivalent; therefore, he could not plead an ascertainable loss under the MPA. *Id.* at 508. *Cf. Hoover v. Mercy Health*, No. ED97495, 2012 WL 2549485, *5 (Mo. Ct. App. July 3, 2012) (court rejected defendant's reliance on *Freeman* for proposition that plaintiff did not allege ascertainable loss where plaintiff did pay part of his bill; "*Freeman* clarified that an 'ascertainable loss' results from the payment of money, not from the fact a bill was issued").

In contrast, in the case at bar, Appellants *did* pay Respondents for the medical services which Respondents provided and for which Respondents overcharged Appellants. *See* Mo. Rev. Stat. § 407.025. Appellants' payments to Respondent took the form of the assignment to Respondents of benefits otherwise payable to Appellants pursuant to insurance policies which Appellants either procured for themselves (the Millsaps) or which were provided to them by their employers in return for their labor (Roberts and Hales). As set forth above, *see supra* at pp. 17-27, the collateral source rule provides that the fact that insurance paid the charges neither reduces the damages owed to Appellants nor constitutes admissible evidence in this case. At the very least, when the Appellants obtained from Respondents medical services in exchange for allowing

Respondents to receive payments from Appellants' insurers, Appellants paid either "money or its equivalent" to Respondents, thereby qualifying Appellants as "purchasers" of the medical services under the MPA.¹⁰

In their filings with the circuit court, Appellants had directed the circuit court's attention to *Plubell v. Merck Co.*, 289 S.W.3d 707 (Mo. Ct. App. 2009), but the circuit court seemed to have misunderstood the point of Appellants' citation to that case. *See* Judgment at p. 4 (LF 1263). In that case consumers who had taken Vioxx alleged, under the MPA, that the manufacturer failed to disclose, and actively concealed, the risks of the drug. *Id.* at 711. Upon appeal of the trial court's class certification ruling, the court of appeals declined to consider the manufacturer's contentions that the putative class representative-consumer had not "purchased" the drug because her insurance provider paid for the prescription. The court noted that common logic would indicate that many of the class members' insurers paid for their prescriptions, which would not make the representative's claims atypical. The court concluded that the plaintiffs stated a claim under the MPA because they alleged "an objectively ascertainable loss." *Id.* at 715. *See*

¹⁰Appellants respectfully suggest that the circuit court's approach to the MPA does not comport with the remedial purpose of the statute. The MPA seeks to supplement common law fraud remedies in order "to preserve fundamental honesty, fair play and right dealings in [consumer] transactions." *Raster v. AmeriStar Casinos Inc.*, 280 S.W.3d 120, 131 (Mo. Ct. App. 2009). "The statute paints in broad strokes to prevent evasion thereof due to overly meticulous definitions." *Id.* (internal citation omitted).

also *Carr-Davis v. Bristol-Myers Squibb Co.*, No. 07-1098, 2009 WL 5206122 (D.N.J. Dec. 30, 2009) (citing *Plubell*). Cf. *Breeden v. Hueser*, 273 S.W.3d 1 (Mo. Ct. App. 2008) (MPA claim appropriate where physician billed patients for single use chemotherapy vials that were used on multiple patients).

Here, too, Appellants sustained an ascertainable loss when their insurers paid, on their behalf, inflated charges for medical services based on deceptive coding practices utilized by Dr. Coin and, ultimately, the Respondents. Appellants have sustained damages under the MPA, and this Court should reverse the trial court's judgment with respect to Appellants' MPA claim.

CONCLUSION

For the foregoing reasons, this Court should reverse the circuit court's grant of summary judgment in favor of Respondents and should remand the case to the circuit court for further proceedings.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE AND SERVICE

I hereby certify that the attached brief complies with Rule 84.06(b) and contains 8,501 words, excluding the cover, this certification and the signature block, as counted by Microsoft Word; that the electronic copy of this brief was scanned for viruses and found to be virus free; and that notice of the filing of this brief, along with a copy of this brief, was sent through the Missouri eFiling System on this 7th day of September, 2012, to:

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