

SC 92700

IN THE SUPREME COURT OF MISSOURI

Alice Roberts, et al.,

Plaintiffs-Appellants,

v.

BJC Health System, et al.,

Defendants-Respondents.

**SUBSTITUTE BRIEF AND APPENDIX OF
RESPONDENT BJC HEALTH SYSTEM**

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STATEMENT OF FACTS

Appellants, individually and on behalf of a purported class bring an action for alleged improper billing for health care services. They allege overcharging by Richard Coin, M.D. and his company, Reconstructive Microsurgery Associates (hereafter also "RMA")¹, for certain surgical procedures, and also allege purported reliance upon that billing by the other health care defendants for alleged overcharging. The central issue as to all Respondents in the case is whether Appellants, on their individual claims, have suffered any injury because of that overcharging, despite having paid nothing for the health care due to either private insurance or workers' compensation coverage. The only issue with regard to Respondents Missouri Baptist Medical Center (hereinafter also "Missouri Baptist") and BJC Health System d/b/a BJC Healthcare (hereinafter also "BJC") is whether Appellant Kevin Hales suffered any damages or an injury-in-fact when he received health care at Missouri Baptist for a work-related injury that was billed to, and paid for entirely by, his employer's workers' compensation insurance carrier.

¹ In 2007, Dr. Coin and RMA were indicted and pleaded guilty on various federal charges as a result of their billing practices. (L.F. 1260). No other Defendant/Respondent herein was indicted.

A. Appellants' Petition

In October 2004, Appellants Alice Roberts, Kevin Hales, and Christy and Tim Millsap, filed this case against Respondents BJC, Missouri Baptist, Sisters of Mercy Health System (hereinafter also “Sisters of Mercy”), St. John’s Mercy Health System d/b/a St. John’s Mercy Medical Center (hereinafter also “St. John’s”), and RMA in the Circuit Court of the City of St. Louis. Appellants’ Petition contains twenty-six (26) counts (ten of which are directed against BJC) dealing principally with three areas: (1) credentialing of physicians, namely Dr. Coin; (2) the allegedly improper and fraudulent coding and billing for health care services provided; and (3) BJC’s alleged duty to oversee the coding and billing of its affiliate hospital, Missouri Baptist, as well as the coding and billing of Dr. Coin and RMA. (*See* L.F. 58-59, 64-71, 78-80, Petition). There is no allegation that BJC provided any health care to any Plaintiff. (*Id.*)

Appellants’ Petition attempts to state claims under numerous theories, and further attempts to certify their claims as a class action with two sub-classes.² (*See* L.F. 48-50, Petition, ¶¶ 102-110). The limited class Appellants seek to represent is as follows:

² Defendant BJC denies this case is proper for class certification.

All natural persons who, during the Relevant Period, were asked or required, through or as a result of miscoding by RMA and/or Coin, to pay, to approve, allow to be paid, or have paid to BJC, SOM, St. John's, RMA or Coin any amounts for PRSM Care and/or related products, services or facilities provided or purportedly provided to **natural persons** during the Relevant Period.

(See L.F. 48, Petition, ¶ 103) (emphasis added).

All Appellants allege RMA miscoded its billing records and as a result overcharged the Appellants. (See L.F. 47, Petition, ¶ 96). Appellants also allege both Respondents Missouri Baptist and St. John's, "miscoded in purported reliance on the notes and records of RMA, and thus, overcharged Appellants Roberts, Hales and Millsaps, as well." (See L.F. 47, Petition, ¶ 98). The Petition admits BJC is a Missouri nonprofit corporation and that Missouri Baptist is a separately incorporated Missouri nonprofit corporation. (See L.F. 23, 29, Petition, caption and ¶¶ 17-18). Appellants allege BJC is responsible for Missouri Baptist's conduct in allegedly overbilling Appellants based on the BJC Affiliation Agreement (See L.F. 30-32, Petition, ¶¶ 22-27) and that it "controlled" Missouri Baptist in certain ways. (L.F. 32, Petition, ¶¶ 28-31).

B. Procedural History of Case From 2004 Filing to November 2008

On June 18, 2004, Plaintiffs Roberts and Hales filed the original version of this lawsuit in the Circuit Court for the City of St. Louis, Cause No. 042-7187.

(Respondents' S.L.F. 9). Plaintiffs purported to file the Petition on behalf of "all persons or entities who are members of [a] class" defined as, "all persons who...were asked or required, through or as a result of miscoding by RMA or Coin, to approve, pay, allow to be paid, and/or have paid...any amounts..."

(Respondents' S.L.F. 31-32). On August 12, 2004, because the class definition included entities such as the insurers or benefit plans that were actually billed and paid for the medical services at issue, Defendant St. John's removed the case to the United States District Court for the Eastern District of Missouri on the basis of preemption by the Employee Income Retirement Security Act of 1974.

(Respondents' S.L.F. 1-78, Notice of Removal).

On October 12, 2004, Plaintiffs dismissed the case without prejudice (Respondents' S.L.F. 111-112) and that same day re-filed in the Circuit Court for the City of St. Louis, adding the Millsap Plaintiffs and modifying the definition of the purported class, including removing the "entity" language. (Respondents' S.L.F. 123-181). This second version, which is now on appeal, changed the definition of the class to be "all natural persons who...were asked or required, through or as a result of miscoding by RMA and/or Coin, to pay, approve, allow to be paid, and/or have paid...any amounts..." (L.F. 48)(emphasis added).

On November 10, 2004, the Defendants again removed the case to federal court (Respondents' S.L.F. 113-184). In challenging the removal, Plaintiffs

contended they were not pursuing claims as beneficiaries of any third-party health plans or insurance companies. (*See* Respondents' S.L.F. 189). Defendants all filed Motions to Dismiss arguing, among other things, that Plaintiffs lacked standing because they has not sustained a cognizable injury-in-fact in so much as all sums were paid by insurance companies and other third-party payers. (*See* Respondents' S.L.F. 229-260).

On March 16, 2005, Judge Jean Hamilton dismissed the case for Plaintiffs' failure to establish Article III standing and failure to demonstrate they suffered an injury-in-fact likely to be addressed by a favorable decision. (Respondents' S.L.F. 420-431). After Plaintiffs filed more briefing, Judge Hamilton amended her Order of Dismissal on May 4, 2005, to remand the case to state court rather than dismiss it outright. (Respondents' S.L.F. 432-436). Defendants appealed the remand order to the Eighth Circuit on the basis that Plaintiffs' lack of standing required dismissal, not remand. *Roberts v. BJC Health Sys.*, 452 F.3d 737, 738 (8th Cir. 2006). After briefing and argument, the Eighth Circuit dismissed the appeal on June 21, 2006, because standing is a requirement of subject matter jurisdiction, making the remand order not appealable. *Id.* The court observed that the likely result of Plaintiffs' failure to plead a cognizable injury would be dismissal in state court after remand, but observed that "[o]ne remedy to this dilemma is including a class member in the case who sustained an injury in fact." *Id.* at 739.

After the 2006 remand, the parties engaged in venue-related discovery and motion briefing. (*See* Circuit Court Docket Sheet, L.F. 14-20). These venue-related activities continued through August 2008, when the venue challenge was exhausted. (*See* Circuit Court Docket Sheet, L.F. 14-20).

C. The November 2008, Agreed-to Discovery Order to Address The Issues of Damages and Injury-In-Fact In Phase One of Merits Discovery

On November 18, 2008, all parties approached the circuit court and agreed to enter a consent order that the first phase of merits discovery would be limited to the issue of whether Appellants had suffered any damages from the alleged overbilling for health care. (Respondents' S.L.F. 471-72). The Discovery Order specifically stated that the damages discovery phase would end with decisions on Respondents Summary Judgment Motions on the dispositive issue of whether Appellants had suffered injury or damages. (Respondents' S.L.F. 471-72).

The November 18, 2008, order states in pertinent part as follows:

[T]he parties shall pursue discovery limited to the issue of standing and named plaintiff's injury in fact. Such discovery can consist of depositions of the named plaintiffs and defendants regarding monies paid for medical services rendered to the named plaintiffs and for third-party payments or premiums, production of documents regarding the tracking of funds paid for the medical services in question, and other discovery

permitted under the rules of procedure so long as it is limited to standing and injury in fact of the named plaintiffs.... Within 30 days of the conclusion of the aforesaid discovery, defendants shall file their motions for summary judgment regarding standing and injury in fact issues.... All other scheduling issues are in abeyance until these motions are decided. (Respondents' S.L.F. 471).

D. Discovery Pertinent to the Claims of Appellant Kevin Hales Pursuant to the November 18, 2008 Order

During this focused discovery phase, Respondents deposed Appellant Kevin Hales, the only plaintiff who alleges Respondents Missouri Baptist and BJC overcharged for health care. (L.F. 44, Petition, ¶¶ 78-80). It is undisputed that the only treatment Kevin Hales received at Missouri Baptist occurred more than eleven years ago on January 25, 2001. (L.F. 207, Deposition of Kevin Hales, p. 38:13-19; 39:4-6)(L.F. 217 Face Sheet from Hales' January 25, 2001, admission to Missouri Baptist). Mr. Hales, who at the time was an employee of Hemsath Concrete, had earlier suffered a work-related injury to his middle and index fingers on his left hand. (L.F. 203, 207, Deposition of Kevin Hales, p. 24:4-24; 38:20-39:6). He went to Missouri Baptist on January 25, 2001, to have a pin removed from his left middle finger. (L.F. 203, 207, Deposition of Kevin Hales, p. 24:4-24; 38:20-39:6).

There is no dispute that Missouri Baptist did not bill Mr. Hales for any services, and Mr. Hales paid nothing for any health care at Missouri Baptist. (L.F. 207, Deposition of Kevin Hales, p. 39:7-40:5; L.F. 217, L.F. 218-219). Rather, Missouri Baptist billed Continental Western, Mr. Hales' employer's workers' compensation carrier, which paid for (or adjusted) all of Mr. Hales' health care at issue at Missouri Baptist. (See L.F. 207, Deposition of Kevin Hales, pp. 39:10-40:5; L.F. 217, Face Sheet from Hales' January 25, 2001, admission to Missouri Baptist; L.F. 218-19, Affidavit of Debra Wierciek, ¶¶ 2-3). Mr. Hales no longer works for Hemsath Concrete. (L.F. 199, Deposition of Kevin Hales, p. 7:10-8:2).

Mr. Hales testified he is not seeking any money for himself and is not suing on behalf of his employer or on behalf of any insurance company. (L.F. 48, Petition, ¶ 103; L.F. 209, Deposition of Kevin Hales, p. 46:10-24). He also testified that neither he, nor his then-employer (Hemsath Concrete), and/or his employer's insurance company sustained any additional charges for health insurance coverage as a result of any of the charges for his health care at Missouri Baptist in January 2001. (L.F. 212, Deposition of Kevin Hales, p. 60:18-61:5).

Also during this focused discovery phase, Appellants disclosed Raymond Janevicius, M.D. as their sole expert on the issues of coding/miscoding and damages. (Respondents' S.L.F. 471-472, November 18, 2008 Order). At his October 9, 2009, deposition, Dr. Janevicius testified he did not have any opinions

whether any of the three named Plaintiffs, including Mr. Hales, had suffered any financial damages as a result of the alleged overbilling for health care services. (L.F. 231, 235-36, 243, Deposition of Raymond Janevicius, M.D., pp. 43:12-44:11; 61:12-62:2; 91:2-19). He also testified he has no opinions about whether Missouri Baptist's or St. John's Mercy Medical Center's billings for Roberts, Hales and Millsap were inappropriate in any way. (L.F. 243, p. 91:2-7).

E. The Motions for Summary Judgment Filed In Accordance With The November 18, 2008, Consent Discovery Order

After this agreed-to, damages-phase discovery and in accordance with the circuit court's November 18, 2008, Order, BJC moved for summary judgment on the issue of damages. (L.F. 124-250, BJC's Motion for Summary Judgment and Statement of Uncontroverted Material Facts). The basis of the Motion was Mr. Hales' lack of standing to sue for the alleged overbilling and/or lack of an injury-in-fact because: (1) only his employer's workers' compensation carrier was billed for and paid for his health care at Missouri Baptist; and, (2) the Missouri Workers' Compensation statutory scheme completely insulated Hales from financial responsibility for that medical care. (L.F. 124-250, BJC's Motion for Summary Judgment and Statement of Uncontroverted Material Facts; L.F. 207, Deposition of Kevin Hales, pp. 39:10-40:5; L.F. 217, Face Sheet from Hales' January 25, 2001, admission to Missouri Baptist; L.F. 218-19, Affidavit of Debra Wierciek, ¶¶ 2-3).

Also in accordance with the November 18, 2008, consent scheduling Order, all other Respondents filed their own dispositive Motions on the issue of damages. (L.F. 251-253; 379-381; 594-600; 740-800). At no time during the briefing for these Motions, did Appellants ever claim, assert, or file a request with the court that they needed more time for discovery on the issues of standing, injury-in-fact and damages, although extensions of time were granted to both plaintiffs and defendants in the ordinary course of summary judgment briefing. (L.F. 7-9).

F. The September 9, 2010, and March 16, 2011, Summary Judgment Orders

On September 9, 2010, the circuit court issued a Memorandum and Order granting in part and denying in part the separate Motions for Summary Judgment or Motions to Dismiss of all Respondents. (L.F. 1214-1223). As to the claims for negligence and for violation of the Missouri Merchandising Practices Act, the circuit court entered judgment for all Respondents, holding Appellants had failed to state a cognizable claim for damages. (L.F. 1222). The court denied the Motions as to all other counts on the basis that the alleged overcharging for health care services qualified as a “threatened or actual injury” because ultimately each of the Appellants was responsible for paying the bills and any overcharges. (L.F. 1217-18).

All parties filed Motions to Reconsider or Clarify the Summary Judgment ruling. (L.F. 1224-1258). On December 23, 2010, the circuit court granted the Motions to Reconsider or Clarify and vacated its September 9, 2010, Order. (L.F. 1259). The parties filed briefs and then argued their Motions to the court in January 2011. (L.F. 7-9, Circuit Court Docket Sheet). On March 16, 2011, the circuit court granted summary judgment to all Respondents on all claims. (L.F. 1260-L.F. 1266). The circuit court noted all of the individual Appellants' pleaded claims suffer from the same factual and legal fallacy: Appellants presented no evidence showing they have been harmed in reality. (L.F. 1262). Ultimately, the circuit court held these Appellants cannot proceed with a massive class action, under any theory, to recover money that "incontrovertibly they never lost." (L.F. 1262).

**G. Rule 84.16 Affirmance By The Missouri Court of Appeals,
Eastern District**

Appellants appealed to the Missouri Court of Appeals for the Eastern District. (Appeal No. ED 96650). On May 15, 2012, the Court of Appeals, in a *per curiam* opinion, affirmed the summary judgments in favor of all Respondents pursuant to Rule 84.16. (BJC's Substitute Separate Appendix (hereinafter "BJC's Supp.App."), A25-A26). In its Memorandum Supplementing Order Affirming Judgment Pursuant to Rule 84.16 (b), the Court of Appeals noted that, regardless

of whether the central issue of damages is characterized as one of standing or as one of failure to prove the element of damages, the undisputed facts show Appellants did not suffer any alleged harm. (BJC's Supp.App., A31). The Court further noted:

The trial court correctly found that Plaintiffs offered no actual proof of damages. Plaintiffs neither received a bill nor made payment because their respective health and workers' compensation carriers paid all the disputed charges. Moreover, Plaintiffs' reliance on the testimony of their medical expert witness, Dr. Janevicius, to prove financial loss does not support their arguments. Dr. Janevicius expressly stated that he had no opinion "as to the actual damages suffered by each plaintiff." He further testified that he had "no opinion... about what money damages these three plaintiffs have suffered."

(BJC's Supp.App., A.31-32).

As to Appellants' argument that they suffered damages because they "incurred" charges, even though they "paid" no medical bill, the Court found that, since Appellants were never exposed to "unconditional liability" for the medical expenses at issue, they never incurred nor paid any of the inflated charges. (BJC's Supp.App., A.33). The parties to any possible dispute over medical bills for Hales' health care could only have been Missouri Baptist, the employer, and the

worker's compensation insurer because his health care at Missouri Baptist was covered by workers' compensation insurance. (BJC's Supp.App., A33). Section 287.140.13(1), RSMo 2000, barred Missouri Baptist from attempting to collect from Mr. Hales any portion of any medical charge for services rendered with respect to his workplace injury. (BJC's Supp.App., A33). The Court also found Appellants' attempt to use the "benefit of the bargain" rule misplaced because that rule only applies as a measure of damages where actual damages have been proven. (BJC's Supp.App., A33-A34). Finally, the Court found the collateral source rule inapplicable because Appellants did not receive a payment from a collateral source in mitigation of damages. (BJC's Supp.App., A34).

Appellants timely filed an Application to Transfer, which this Court granted on August 14, 2012.

RESPONSE TO APPELLANTS' SOLE POINT RELIED ON
THE TRIAL COURT DID NOT ERR IN GRANTING SUMMARY
JUDGMENT TO RESPONDENT BJC BECAUSE APPELLANT HALES
SUFFERED NO DAMAGE OR INJURY-IN-FACT IN THAT, BY
OPERATION OF MISSOURI'S WORKERS' COMENSATION LAW, HE
WAS NOT FINANCIALLY LIABLE OR RESPONSIBLE FOR, AND IN
FACT WAS NOT BILLED FOR AND PAID NOTHING FOR, THE
HEALTH CARE SERVICES HE RECEIVED AT MISSOURI BAPTIST.

ARGUMENT

A. Standard of Review

A defending party establishes its right to summary judgment by showing: (1) facts negating any one of the claimant's elements necessary for judgment; (2) that the claimant, after an adequate period of discovery, has not been able and will not be able to produce evidence sufficient to allow the trier of fact to find the existence of any one of claimant's elements; or (3) facts necessary to support his properly pleaded affirmative defense. *ITT Commercial Finance Corp. v. Mid-America Marine Supply Corp.*, 854 S.W.2d 371, 381 (Mo. banc 1993). "A movant for summary judgment need not show entitlement to summary judgment by unassailable proof." *Stewart Title Guar. Co. v. WKC Rest. Venture Co.*, 961 S.W.2d 874, 884 (Mo.App. W.D. 1998).

The propriety of summary judgment is always a question of law to be reviewed essentially *de novo*. *Turner v. School Dist. of Clayton*, 318 S.W.3d 660, 664 (Mo. banc 2010)(citing *ITT Commercial Fin. Corp. v. Mid-America Marine Supply Corp.*, 854 S.W.2d 371, 376 (Mo. banc 1993)). This Court may affirm the grant of summary judgment under any appropriate theory supported by the record. *Id.*; *Keylien Corp. v. Johnson*, 284 S.W.3d 606, 608 (Mo.App. E.D. 2009). This Court is bound to view the record in the light most favorable to the non-movant, taking as true facts set forth by affidavit or otherwise in support of the moving party's Motion that are not properly contradicted by the non-moving party's response. *Ruppel v. City of Valley Park*, 318 S.W.3d 179, 184 (Mo.App. E.D. 2010).

B. Appellants ignore certain important procedural facts.

As an initial matter, it must be noted that Appellants ignore important procedural facts which put the issues before this Court in the proper context.

1. The parties agreed to have the issues of injury-in-fact and damages decided before other aspects of the case, and Appellants do not dispute there was adequate time for discovery on these issues.

After an extended period of time during which the parties fought over the issue of standing (in federal court) and venue (in state court), they faced the issue of the merits of this potential class action. On November 18, 2008, all parties approached the circuit court and agreed to enter a consent order that discovery should be separated out into merits discovery on damages, on the one hand, and class discovery, on the other. They agreed the first phase of discovery would deal with the issue of whether Appellants had suffered any damages from the alleged overbilling for health care. (Respondents' S.L.F. 471-72).

The November 2008 discovery order clearly shows all parties requested the trial court to address the damages and standing issues before considering class certification. Such a strategy decision makes sense in terms both of judicial economy and the expense to all parties. That is, if these Appellants could not prove they suffered damages, there would be no need to participate in the gigantic undertaking of conducting discovery or the other burdensome aspects of class action litigation. The bottom line, though, of this approach is that the dispositive

motions, if granted, would end the case.³ Therefore, Appellants needed to be as prepared with their evidence for the dispositive Motions as they would be for a trial.

At no point during this damages discovery phase, did Appellants ever take the position that the time for discovery should be lengthened to allow for more discovery to occur to help in opposing the Motions. Rather, the damages discovery phase ended, and, in accordance with the November 18, 2008, Order, the Respondents timely filed dispositive motions. Appellants then filed responses to each. Appellants made no objections to the briefing on those Motions going forward. They did not file any affidavit pursuant to Rule 74.04(f) either to support a request the circuit court not enter summary judgment or to continue the proceeding to permit affidavits to be obtained or other depositions to be taken. Appellants never made mention that more discovery must occur before the circuit court could fairly decide the damages issue as framed by the parties. Thus, there can be no dispute that the circuit court properly considered the damages issue

³ That these Appellants could not prove they suffered damages would not foreclose the opportunity for another potential plaintiff to file a similar class action or individual lawsuit. *See Ressler v. Clay County, Missouri*, 2012 WL 2285980, *5 (Mo.App. W.D. June 19, 2012).

before class certification and did so upon a record which, by consent of all parties, was complete as to that issue.

2. **Appellants' counsel made the strategic decision to exclude from the putative class any parties who would have actually suffered damages from the alleged overbilling for health care.**

There is yet one more facet to consider in the termination of this case on Appellants' lack of damages – party selection. During this litigation, Appellants intentionally changed their putative class definition to limit it to “all natural persons,” thereby specifically removing the prior inclusion (in the original petition) of third-party payers or other entities which were actually billed for the health care at issue here and which actually paid the bills at issue in this case. (L.F. 48, Petition, ¶ 103). Mr. Hales testified he was not bringing an insurance claim or any claim on behalf of the insurance carrier and was not seeking money on his own behalf. (L.F. 209, Hales Deposition, p. 46:10-24). Certainly, it is more than reasonable to assume Appellants' counsel knew well that this strategic decision of limiting the class members to exclude those who were actually billed and who actually paid could lead to an outcome adverse to their chosen clients.

C. The Trial Court did not err in granting Summary Judgment to Respondent BJC because Mr. Hales suffered no damage or injury-in-fact in that, by operation of Missouri's Workers' Compensation Law, he was not financially liable or responsible for the health care services he received at Missouri Baptist, and , in fact, was never billed for, and personally paid nothing for, those health care services.

- 1. Missouri's workers' compensation statutory scheme shields Kevin Hales from being financially responsible for the health care services he received at Missouri Baptist.**

Mr. Hales' January 25, 2001, health care at Missouri Baptist was for a work-related injury. In November 2000, more than 11 years ago, he was injured on the job, sustaining a saw wound to his left middle and index fingers. (L.F. 203, Hales Deposition, p. 24:4-24 and L.F. 207, pp. 38:20-39:6). His employer, therefore, was required under Missouri Workers' Compensation Law to "provide" and pay for the health care resulting from this work-related injury. § 287.140, RSMo. It is undisputed Hales' employer in fact did so in conformance with its statutory obligations. (L.F. 217-218, Affidavit of Debra Wierciek).

Missouri Workers' Compensation Law prohibits the health care provider from billing the employee for health care received for a work-related injury.

Section 287.140, RSMo. A few subsections of section 287.140, RSMo make this clear. That statute provides in pertinent part:

1. In addition to all other compensation, **the employee shall receive and the employer shall provide such medical, surgical, chiropractic, and hospital treatment... as may reasonably be required after the injury or disability, to cure and relieve from the effects of the injury....**

Where the requirements are furnished by a public hospital or other institution, payment therefor shall be made to the proper authorities. . . .

§ 287.140(1), RSMo (1993) (emphasis added).⁴ Another subsection of that statute unequivocally prohibits the health care provider from billing the employee-patient for health care received for a work-related injury:

13. (1) **No hospital, physician or other health care provider**, other than a hospital, physician or health care provider selected by the employee at his own expense pursuant to subsection 1 of this section, **shall bill or attempt to collect any fee or any portion of a fee for services rendered to an employee due to a work-related injury** or report to any credit reporting agency any failure of the employee to make such

⁴ Subsection 1 was slightly modified as part of the 2005 tort reform legislation, L.2005, S.B. Nos. 1 & 130, § A., but the amendment has no impact on this case and the version in effect in 2001 is cited above.

payment, when an injury covered by this chapter has occurred and such hospital, physician or health care provider has received actual notice given in writing by the employee, the employer or the employer's insurer.

§ 287.140.13(1), RSMo (1993) (emphasis added).

To further protect the employee-patient from being billed for health care, the same statute gives him or her a cause of action for actual damages and provides for attorney's fees in the event a health care provider pursues an action to collect from him or her:

(4) If a hospital, physician or other health care provider or a debt collector on behalf of such hospital, physician or other health care provider pursues any action to collect from an employee after such notice is properly given, the employee shall have a cause of action against the hospital, physician or other health care provider for actual damages sustained plus up to one thousand dollars in additional damages, costs and reasonable attorney's fees.

§ 287.140.13(4), RSMo (1993). Thus, the statute completely insulates the employee-patient and limits the health care provider to a collection action against only the employer or insurer. § 287.140.13(5), RSMo (1993).

The Workers' Compensation statutes, therefore, clearly provide that Mr. Hales could not be billed for or be financially responsible for the health care he received at Missouri Baptist in connection with his work-related injury. In fact, Missouri Baptist merely attempting to collect the bill from Mr. Hales would have subjected it to additional damages, costs, and attorney's fees. § 287.140.13(4), RSMo. Thus, Hales did not, as Appellants assert, become liable for or subject to the charges for his health care at Missouri Baptist. As a result of Hales' protection from financial responsibility, under the Workers' Compensation Law, for the health care services received as a result of a work-related injury, he has absolutely no standing because he suffered no damages as a result of the alleged fraudulent billing.

Appellants argue the circuit court misconstrued the workers' compensation law because it ignored other subsections of the law which, according to Appellants, "betrays a lack of understanding of the workers' compensation system as a whole." (Substitute Brief of Appellants, pp. 28-29). Appellants argue the workers' compensation law merely puts in place a "stay" whereby the provider is not supposed to bill the patient for services, but that if it is later determined that the injury was not work-related, the provider can bill the employee. (Substitute Brief of Appellants, p. 29). The problem with Appellants' argument, however, is that

there is no dispute in this case that the health care Mr. Hales received at Missouri Baptist more than a decade ago was work-related.

Furthermore, over the last 11 years, no one has either disputed that the health care was work-related, or has attempted to bill or collect from Hales for those work-related charges. Thus, the provisions of the workers' compensation law dealing with what happens if the injury is later found not to be work-related are irrelevant as to this individual Appellant. The fact of the matter remains that for a work-related injury, the statute unequivocally prohibits the health care provider from billing the employee-patient for health care received for that work-related injury. That is the case here for Mr. Hales.

As to Respondent St. John's, Appellants claim its actions demonstrate that St. John's believed it could send notices to its work-related patients reminding them of their ultimate liability for medical charges. (Substitute Brief of Appellants, pp. 15 and 30). Despite their best efforts to lump Missouri Baptist in with St. John's (*see* Substitute Brief of Appellants, pp. 3, 15), there is absolutely no evidence to support that Missouri Baptist ever sent to Mr. Hales any such notices. The evidence is that the language on Missouri Baptist's Authorization form is different from that of St. John's. (L.F. 990). Further, Mr. Hales was never billed for the health care he received from Missouri Baptist, which was billed to and paid by his employer's workers' compensation insurance carrier. (L.F. 207, p. 39:7-

40:5; L.F. 217, 218, ¶¶ 2-3). Finally, irrespective of the authorization form or what notices St. John's may have sent, it is ludicrous for Appellants to argue, as they appear to be trying to do, that a consent to treatment form or a pre-printed notice on the bottom of St. John's billing statement could override Missouri's workers' compensation statutory scheme and its prohibition upon collecting medical expenses work-related injuries from the employee. *See* § 287.140.13(1), RSMo (1993).

Appellants also argue the circuit court erred in holding that the claims belong to the insurers or employers, rather than to them. However, Appellants wrongly rely on the workers' compensation law's provisions which give the physically injured employee the right to control any legal action against a third party who might have liability for their work-related, physical injury. (Substitute Brief of Appellants, p. 30-31). The statutory language upon which Appellants rely clearly addresses only those actions against third parties *who are or may be liable for the work-related, physical injury*. *See* Mo. Rev. Stat. § 287.150 ("Where a third person is liable to the employee or to the dependents, *for the injury or death*, the employer shall be subrogated to the right of the employee or to the dependents against such third person...")(emphasis added). Here, Appellants do not assert or allege St. John's or Missouri Baptist was liable for the work-related, physical injury for which they sought health care. Rather, the allegations are that each is

liable for the “injury” of the distinctly different event of alleged overbilling. The damages, if any, for the alleged overbilling were incurred by the employers and insurers, if anyone at all, and not Mr. Hales.

Appellants also assert they are the “real parties in interest,” and hence have standing to bring these claims, because, although they paid nothing to Respondents, payment by an insurer on an insured’s behalf does not divest the insured, in the absence of an assignment, to title to the action. (Substitute Brief of Appellants, pp. 13-14). Appellants’ argument in this regard, however, ignores the unique circumstances present in Mr. Hales’ claims against BJC and Missouri Baptist. Again, there is no dispute that the health care Missouri Baptist provided to Mr. Hales for a work-related, physical injury and was billed to, and paid for by, his employer’s workers’ compensation insurance carrier. As such, Missouri Baptist was prohibited by law from billing or attempting to bill Mr. Hales for that health care. *See* § 287.140.13(1) RSMo (1993).

Although under the workers’ compensation statute, Mr. Hales may have retained a right to bring an action against a third party who caused his work-related physical injury, this would not have included a claim against Missouri Baptist or BJC, because neither of those entities caused Hales’ physical injury. Appellants’ arguments as to assignment and the right to bring actions against third-parties are

simply misplaced in the context of Appellant Hales and the health care he received for his work-related injury.

Thus, by operation of the Workers' Compensation Law, Mr. Hales never "incurred" medical expenses for his work-related health care at Missouri Baptist, even as Appellants define that term. Citing to *Berra v. Danter*, 299 S.W.3d 690, 697 (Mo.App. E.D. 2009), Appellants argue they suffered damages because "incur" means "to become liable for or subject to," which is "not the same as paying." (Substitute Brief of Appellants, p. 16). Even assuming Appellants are correct in distinguishing between "incurred" and "paid," it is irrelevant in the context of Mr. Hales' decade old, work-related health care at Missouri Baptist. Here, he was never billed for and never paid (as will be discussed further in the next subsection) for the work-related health care charges. Further, because they were work-related, he never "incurred" financial responsibility for them by operation of the workers' compensation law.

2. **Appellant Kevin Hales never "incurred" any financial responsibility or liability for the health care services provided by Missouri Baptist because he was never billed for, nor paid for, those health care services.**

Appellants do not dispute three key facts: (1) that Kevin Hales' only health care at Defendant Missouri Baptist occurred more than 11 years ago on January 25,

2001; (2) that all of Mr. Hales' health care at Missouri Baptist was provided and paid for by his employer's workers' compensation carrier; and, (3) that Mr. Hales was neither billed for nor paid anything for the health care he received on January 25, 2001. With these admissions, the only conclusion to be reached is that Mr. Hales suffered no damages or injury-in-fact, and therefore, the circuit court properly entered judgment as a matter of law in BJC's favor.

“Standing requires a party seeking relief to have a legally cognizable interest in the subject matter and to have suffered a threatened or actual injury.” *Lett v. City of St. Louis*, 24 S.W.3d 157, 160 (Mo.App. E.D. 2000)(citing *Wahl v. Braun*, 980 S.W.2d 322, 325 (Mo.App. E.D. 1998)). “To have standing, the party seeking relief must show two things: that he is sufficiently affected by the action he is challenging to justify consideration by the court of the validity of his action, and that the action violates the rights of the particular party who is attacking it **and not some third party.**” *Id.* (emphasis added).

In his deposition, Mr. Hales judicially admitted he suffered no financial damages because he is not seeking any money damages. He testified he is not seeking any money for himself, or on behalf of his employer or for any insurance company (the latter two of which are excluded from Appellants' proposed class definition). (*See* L.F. 209, Hales Deposition, p. 46:10-24; *see also*, L.F. 134, BJC's Statement of Uncontroverted Material Facts, ¶ 16; L.F. 812, Plaintiffs' Response, ¶

16). This candid testimony is dispositive of Hales' entire case against Respondent BJC because, Mr. Hales judicially admitted the central damages issue:

Q. You're trying to recover monies to put in your own pocket, correct?

A. **No. I'm not seeking any, you know, money on my behalf.**

(L.F. 209, pp. 46:21-24) (emphasis added). Mr. Hales, therefore, judicially admitted he suffered no damages because he is not seeking any money damages.

The undisputed facts also show Mr. Hales was never billed for the January 25, 2001, health care he received at Missouri Baptist. Mr. Hales admitted his only care at Missouri Baptist occurred on January 25, 2001, which was more than 11 years ago. (L.F. 207, pp. 38:13-39:6). He testified he was never billed for that health care. (L.F. 207, p. 39:7-15). Rather, Mr. Hales' employer's workers' compensation insurance carrier was billed for and paid for the January 25th care. (L.F. 207, pp. 39:16-P.40:5; L.F. 218, ¶ 2). The face sheet from the Missouri Baptist Medical Center admission specifically lists Mr. Hales' employer as Hemsath Concrete and the insurance to be billed was "Western Continental." (L.F. 217). Missouri Baptist billed Continental Western for Mr. Hales' health care, and Continental Western paid the bill. (L.F. 218, Affidavit of D. Wierciak, ¶ 2). Mr. Hales paid nothing – not even a co-pay – to Missouri Baptist for the health care at issue. (L.F. 207, pp. 39:16-40:5; L.F. 218, ¶ 3).

In an attempt to argue the irrelevance of Mr. Hales not having been billed for or paying anything for the health care, Appellants assert their expert, Dr. Janevicius, “definitively stated that the Respondents miscoded (including unbundling, upcoding and fabrication of procedures). (Substitute Brief of Appellants, p. 7). Appellants also assert this miscoding resulted in improper medical charges to the Appellants, although D. Janevicius did not render an opinion as to the dollar amounts of the fraudulent charges.” (Substitute Brief of Appellants, p. 7).

Appellants’ version of Dr. Janevicius’ testimony is nothing short of a stunning mischaracterization. In reality, Dr. Janevicius testified *he did not have any opinions* about whether the individual Appellants, including Mr. Hales, suffered *any* financial damages as the result of any alleged overbilling – not merely that he could not quantify the amount of any damages. (L.F. 231, 235-36, 243, pp. 43:12-44:11; 61:12-62:2; 91:2-19).

Q. This lawsuit, the actual petition that was filed, Doctor, stated in paragraph 17 this action specifically seeks to recover all damages suffered by the named plaintiffs, which are Hales, Millsap and, of course, Roberts. Is it fair to say you don’t have any opinion as to the actual damages suffered by each plaintiff?

A. That’s correct.

(L.F. 231, pp. 44:4-11).

Q. I assume you've never been hired by anyone [in this case] to give an opinion about whether a patient suffered financial damages; is that correct?

A. That's correct.

(L.F. 232, pp. 46:24-47:3).

Q. Do you anticipate doing any further analyses regarding the financial impact on any of the particular patients, Hales, Millsap and Roberts?

A. I don't know.

Q. You've not been asked to do anything so far?

A. Correct.

(L.F. 233, pp. 50:15-22).

Q. You are not expressing an opinion, are you, as to whether any of these individual plaintiffs, Roberts, Millsap or Hales has suffered any financial damages?

[objection to the form of the question by Plaintiffs' counsel]

A. That's correct.

(L.F. 235-236, pp. 61:21-62:2)(emphasis added).

Q. ...you offer no opinion today about what money damages these three plaintiffs have suffered, correct?

[objection to the form of the question by Plaintiffs' counsel]

A. That is correct.

(L.F. 240, pp. 81:7-11)(emphasis added).

Q. You don't have any opinion as to whether any of Roberts, Hales or Millsap sustained any financial damages as a result of any of this up-coding or misbilling, do you?

A. I do not know if they did or not.

(L.F. 243, pp. 91:15-19).

Dr. Janevicius also testified he has no opinions about whether Missouri Baptist's billings for Roberts, Hales and Millsap were inappropriate in any way. (L.F. 243, p. 91:2-7). Yet, Appellants completely mischaracterize Dr. Janevicius' testimony at page 15 of their Substitute Brief where they assert, citing to the Janevicius deposition testimony, that "the record in this case contains evidence that establishes that Respondents did, in fact, overcharge Appellants." Although Dr. Janevicius expressed opinions as to whether certain of Dr. Coin's charges were inappropriate, he clearly testified he has no opinions about whether Missouri Baptist's or St. John's Mercy Medical Center's billings for Roberts, Hales and Millsap were inappropriate in any way. (L.F. 243, p. 91:2-7). Further, he expressly testified he did not have an opinion as to whether or not the named

Appellants had suffered any damages.⁵ (L.F. 243, p. 91:15-19). Finally, it is undisputed that Missouri Baptist and BJC never billed anything at all to Mr. Hales. (L.F. 207, Deposition of Kevin Hales, p. 39:7-40:5; L.F. 217, L.F. 218-19). This is directly contrary to Appellants' mischaracterizations at pages 25 and 28 of their Substitute Brief that workers' compensation paid "some" of the charges as to Mr. Hales. Mr. Hales' employers' workers' compensation insurance carrier paid ALL the Missouri Baptist charges, not "some." (L.F. 207, Deposition of Kevin Hales, p. 39:7-40:5; L.F. 217, L.F. 218-19). Thus, there is no evidence at all that Respondents Missouri Baptist and BJC overcharged Appellants.

⁵ At no point during this damages discovery phase did Appellants' counsel ever take the position that the discovery period should be lengthened or that Dr. Janevicius was not yet ready to be produced for deposition. There was no objection made at the time of briefing and hearing on the Motions for Summary Judgment that more time was needed for Dr. Janevicius to prepare his damages opinions or that Respondents had failed to ask Dr. Janevicius the right questions at deposition or otherwise failed to elicit at deposition his full damages opinions. Appellants never submitted any additional affidavits from Dr. Janevicius in opposition to the Motions for Summary Judgment. Thus, the total of Dr. Janevicius' damages opinions were before the circuit court.

Thus, it is uncontroverted that Mr. Hales was never billed for any of the health care services he received at Missouri Baptist and did not pay for it. The circuit court correctly concluded in its March 2011 summary judgment order that Mr. Hales failed to show he was damaged in any way as a result of the allegedly improper billing.

3. The Collateral Source Rule is irrelevant to this analysis.

a. The nature of the Collateral Source Rule under Missouri law.

The collateral source rule does not apply in this case because Mr. Hales has not suffered any loss for which he was compensated by a collateral source or any source. A review of Missouri law on damages and the role of the collateral source rule shows why the rule has no bearing on Mr. Hales' standing to sue here.

The collateral source rule is an evidentiary doctrine used to determine whether proof of mitigation of damages should be inadmissible at trial. *Washington v. Barnes Hospital*, 897 S.W. 2d 611, 619-621 (Mo. banc 1995); *Iseminger v. Holden*, 544 S.W.2d 550, 553 (Mo. banc 1976); *Kickham v. Carter*, 335 S.W.2d 83, 90 (Mo. 1960). Its main tenet is that a wrongdoer should not benefit from outside payments by others made to the plaintiff that reduce plaintiff's losses from the injury the defendant caused. *Washington, supra*, at 619; *Kickham, supra*, at 90.

The first Missouri case to articulate the collateral source rule with respect to insurance payments appears to be *Dillon v. Hunt*, 16 S.W. 516 (Mo. 1891). In *Dillon*, fire caused damage to a portion of Hunt's building. Efforts to safely bring down a fire-damaged wall resulted in it falling on plaintiff Dillon's building, damaging both the building and the goods inside. *Id.* at 517. Dillon's insurer paid him for the damage to the building and its contents, and Dillon sued Hunt for the damage. *Id.* At Hunt's request, the trial court instructed the jury that plaintiff's damages should be reduced by the amount of the insurance payments he received. *Id.* at 517-18. The jury followed the instruction and Dillon appealed.

In reversing the jury verdict, the Court held the instruction was erroneous: "Few propositions have been so universally accepted and settled as this...[T]o permit a reduction of damage [by the amount of payments made by others]... would be to allow a wrong-doer to pay nothing, and take all benefit of a policy of insurance without paying the premium." *Id.* at 519.

Approximately 100 years after *Dillon*, this Court described this evidentiary doctrine as an exception to the general rule that damages in tort cases should be compensatory for losses only. *Washington v. Barnes Hospital*, 897 S.W.2d 611, 621 (Mo. banc 1995). *Washington v. Barnes Hospital* involved, in part, analysis of whether the collateral source rule could properly operate to bar evidence at trial of a free, publicly-available, special education program for the injured minor, in

opposition to plaintiff's evidence of the expense of a private school. *Id.* at 619-20. This Court articulated its unwillingness to permit the so-called "collateral source" of the free education to allow a windfall recovery to the plaintiff for the value of the private special education program. *Id.* at 621. Because plaintiff had not entered into any agreement or bargain as to the expense of this special education, this Court held the collateral source rule could not be applied to prevent the defendant from introducing evidence of the public program: "We reject the concept that the collateral source rule should be utilized solely to punish the defendant." *Id.*

Clearly, as was seen in *Washington v. Barnes Hospital*, the collateral source rule has its limits; a plaintiff must incur or pay expenses to invoke this doctrine at trial. *E.g.*, *Washington v. Barnes Hospital*, 897 S.W.2d at 620-21; *Ephland v. Mo. Pac. Ry. Co.*, 57 Mo.App. 147 (Mo.App. 1894). "To award [a claimant] compensation for medical expenses for which she has no liability would result in a windfall rather than compensation." *Farmer-Cummings v. Personnel Pool of Platte County*, 110 S.W.3d 818, 822 (Mo. banc 2003).

This Court again illustrated this limitation on the reach of the collateral source rule in the *Farmer-Cummings* case. There, plaintiff claimed she suffered asthma caused by the inadequate air quality in her workplace. 110 S.W.3d at 820. She was out sick and had medical treatment before she filed a workers'

compensation claim in which she asserted she was entitled to recover the total amount originally charged for medical treatment. From that total value, the Industrial Commission subtracted the amounts that had either been written off or adjusted downward. *Id.* The remaining amounts of the bills were paid either by Medicaid, her private health insurer, Ms. Farmer-Cummings herself, or were still outstanding. *Id.* The Industrial Commission awarded Ms. Farmer-Cummings the amount of the original bill, less the amounts that had been either written off or adjusted downward. *Id.*

Ms. Farmer-Cummings appealed the commission's award, asserting that she was entitled to recover the dollar total on the original billing statements and that any adjustments or write-offs should not reduce her recovery. *Id.* at 820-21. This Court described the real issue in the case as being whether the original medical bills remained "fees and charges" under the Workers' Compensation Law collectable by the employee if they are subsequently reduced or written off by the provider in the collection process. *Id.* at 821. "To award Ms. Farmer-Cummings compensation for medical expenses for which she has no liability would result in a windfall rather than compensation." *Id.* at 822.

In reaching the conclusion that plaintiff was not entitled to collect those amounts adjusted/written off, this Court recounted that two other cases had already determined that an employee was not entitled to recover dollar amounts which

health care providers had written off and extinguished the claimant's liability therefor. *Id.* (citing *Mann v. Varney Constr.*, 23 S.W.3d 231, 233 (Mo.App. E.D. 2000) and *Lenzini v. Columbia Foods*, 829 S.W.2d 482, 487 (Mo.App. W.D. 1992)). This Court observed with approval that “[i]mplicit in both decisions [was] the requirement of actual liability on the part of the employee.” *Id.* at 821. The Court held that “Ms. Farmer-Cummings’ fees and charges include only those amounts that must be paid for her healthcare for which she would otherwise be liable.” *Id.* at 822.

The core concept of the collateral source rule when insurance payments are involved has been termed the “benefit of the bargain.” *E.g.*, *Washington v. Barnes Hospital*, 897 S.W.2d at 621. This concept seems to be commonly misinterpreted (as Appellants did in this case in their brief submitted to the Court of Appeals) as a court declaring some affirmative rights of a plaintiff. It is important to understand, though, that in this setting, this concept is really about precluding a tortfeasor from benefiting from insurance coverage he had no involvement in securing, rather than enforcing a plaintiff’s contractual rights against an insurance company.

“Benefit of the bargain” damages are a measure of damages often used in cases involving breach of contract or claims of fraud or deceit. *See Inauen Packaging Equipment Corp. v. Integrated Industrial Services, Inc.*, 970 S.W.2d 360, 368 (Mo.App. W.D. 1998); *Auffenberg v. Hafley*, 457 S.W.2d 929, 937

(Mo.App. 1970). The benefit of the bargain rule in the case of breach of contract entitles the non-breaching party to the loss the fulfillment of the contract would have avoided or that its breach has caused. *Dierkes v. Blue Cross and Blue Shield of Mo.*, 991 S.W.2d 662, 669 (Mo. banc 1999). In other words, the party injured by the breach of contract is entitled to the value of the performance of the contract so as to place him in the position he would have been in had the contract been performed. *Morehouse v. Behlmann Pontiac-GMC Truck Service, Inc.*, 31 S.W.3d 55, 62 (Mo.App. E.D. 2000).

The benefit of the bargain rule in the case of damages for fraud and deceit, including under the Merchandising Practices Act, allows the defrauded party to be awarded the difference between the actual value of the product received and what its value would have been if it had been as represented, as measured at the time of the transaction. *Heberer v. Shell Oil Co.*, 744 S.W.2d 441, 443 (Mo. banc 1988); *Schoenlein v. Routt Homes, Inc.*, 260 S.W.3d 852, 854-55 (Mo.App. E.D. 2008).

Neither the collateral source rule nor the benefit of the bargain rule of damages operates to support Mr. Hales' claim that he suffered damages and has standing to sue for the alleged overbilling for medical care. Both concepts would require Mr. Hales' having an actual loss or, at a minimum, an obligation to pay for the health care he received at Missouri Baptist. By operation of the Workers' Compensation Law, Mr. Hales has neither of these.

- b. The Collateral Source Rule, and the related benefit of the bargain concept, cannot operate here to establish Appellants suffered damages or injury-in-fact as to Appellant Hales because the Workers' Compensation Law insulates him from having either a loss or an obligation to pay for the health care services he received from Missouri Baptist.

i. The Traditional or Conventional Application of the Collateral Source Rule In Workers' Compensation Third-Party Actions

The typical application of the collateral source rule is in a personal injury action brought for injuries inflicted by a defendant for which the plaintiff had insurance covering the specific loss alleged, i.e., the plaintiff suffered a loss and/or was obligated to pay expenses to which the collateral source rule applied. *See e.g., Buatte v. Schnuck Markets, Inc.*, 98 S.W.3d 569 (Mo.App. E.D. 2002); *Lampe v. Taylor*, 338 S.W.3d 350 (Mo.App. S.D. 2011); *Kickham v. Carter*, 335 S.W.2d 83 (Mo. banc 1960). The collateral source rule also operates in similar fashion in the context of losses in non-personal injury cases; that is its application is dependent upon the plaintiff having suffered a monetary loss or having incurred an obligation to pay as a result of the defendant's conduct. *See e.g., Protection Sprinkler Co. v.*

Lou Charno Studio, Inc., 888 S.W.2d 422 (Mo.App. W.D. 1994); *Jim Toyne, Inc. v. Adams*, 916 S.W.2d 381 (Mo.App. W.D. 1996).

In other words, the typical collateral source rule application involves a plaintiff who suffered personal injury inflicted by the defendant and who sued the defendant for those personal injuries and damages, including his own medical expenses. That is, the defendant physically injured the plaintiff, and the plaintiff (or his employer pursuant to workers' compensation coverage) either incurred, was charged for, and/or paid for the medical care received to treat that physical injury. What many of the cases cited by Appellants have in common is that the plaintiff had an actual loss or an obligation to pay certain expenses, but because there was insurance available to cover those expenses, did not actually pay those expenses. *E.g., Kenniston v. McCarthy*, 858 S.W. 2d 268, 270 (Mo.App. E.D. 1993). The defendant in each of those cases then sought to introduce at trial the evidence of payment by insurance or another collateral source to reduce plaintiff's claim as to those expenses. None of Appellants' cited cases support the proposition that the collateral source rule can provide standing for an injured party to sue a defendant for damages where neither loss nor obligation to pay is present. Nor do any of Appellants' cited cases support the proposition that the collateral source rule applies in the context of medical expenses incurred for a work-related injury when that injury was not caused by a third-party.

ii. Appellants' Chosen Cases Are Inapposite

A review and discussion of a couple of the cases relied upon by Appellants is instructive as to the typical application of the collateral source rule and why it does not apply here. As will be seen in the following cases, the insurance coverage which is commonly held excluded by the collateral source rule is coverage for the specific type of loss for which the plaintiff then sued a third party. That is not the factual situation present in Mr. Hales' claims against Missouri Baptist and BJC.

In *Fust v. Francois*, 913 S.W.2d 38 (Mo.App. E.D. 1995) (cited by Appellants at p. 19 of their Substitute Brief), the Fusts sued Francois for malicious prosecution arising out of an earlier suit which Francois had brought against them. *Id.* at 42. The Fusts sought, among other damages, recovery of the attorneys' fees they were forced to expend in defending the suit Francois had brought against them. *Id.* at 46-47. Francois sought to have evidence admitted that the Fusts were not actually out of pocket any amount for attorneys' fees from the earlier suit because their liability insurer paid their counsel. *Id.* at 46. The trial court excluded any testimony showing that the Fusts did not pay any attorneys' fees in defending the underlying action and the appellate court affirmed. *Id.* at 46-47. The court reasoned that in the malicious prosecution context, the damages are shown by testimony concerning the law firm's services and the amount of those services, and whether the Fusts were the ones who actually paid the law firm directly is

irrelevant. *Id.* at 47. Thus, the Fusts insurance coverage, the evidence of which was excluded by the collateral source doctrine, was coverage for the specific type of loss – i.e., attorney’s fees – for which the Fusts then sued Francois to recover.

In *Womack v. Crescent Metal Products, Inc.*, 539 S.W.2d 481 (Mo.App. 1976) (cited by Appellants at p. 26 of their Substitute Brief), the plaintiff, a cook’s helper, brought suit against the manufacturer of a metal serving cart. Plaintiff was injured when the metal serving cart, which had a sharp metal edge near the bottom, was pushed against her, cutting her right heel and severing her Achilles’ tendon. *Id.* at 482. Because the injury was work-related, plaintiff also received compensation for her injury from her employer’s workers’ compensation carrier. *Id.* At trial, the court refused to give a tendered instruction removing from the jury’s consideration the workers’ compensation payments received and refused to grant plaintiff a mistrial on the basis of numerous references at trial to workers’ compensation payments. *Id.* The appellate court reversed and remanded for a new trial on the issue of damages, holding the evidence of workers’ compensation benefits was wholly irrelevant to the determination of liability or damages. *Id.* at 485. Thus, here again as in *Fust*, the workers’ compensation insurance coverage, the evidence of which should have been excluded by the collateral source doctrine, was coverage for the specific type of loss – i.e., injury to plaintiff’s heel and tendon – for which Womack then sued Crescent Metal Products to recover. *See*

also *Douthet v. State Farm Mut. Auto. Ins. Co.*, 546 S.W.2d 156 (Mo. banc 1977)(cited by Appellants on p. 26 of their Substitute Brief and finding the collateral source rule operated to preclude a reduction in plaintiff's recovery for physical injuries resulting from an auto accident by the amount plaintiff's employer's workers' compensation carrier paid for health care to address those physical injuries).

iii. The Fact Pattern Here Is Outside The Traditional Application of the Collateral Source Rule

Here, Mr. Hales' alleged injury is the overbilling/fraudulent billing for medical care. He has not alleged he had an agreement of any kind with either his employer or his employer's workers' compensation insurance carrier to reduce his losses from overbilling or fraudulent billing. Yet, Mr. Hales alleges the workers' compensation insurance provided by his employer to cover work-related injuries is a "collateral source" to his claim for overbilling/fraudulent billing. Because this was a work-related injury – which is undisputed – Mr. Hales, by operation of the Workers' Compensation Law, was never financially responsible or liable for the health care services at issue. (*See discussion supra*). While the workers' compensation insurance payment may be "collateral" to any possible claim Mr. Hales might have against a third-party who caused his work-related injury (*See*

Womack and Fust, supra), it most certainly is not collateral to the injury he alleges in this case – the improper billing.

This case presents a fact pattern outside the traditional application of the collateral source rule. Mr. Hales' employer provided Hales insurance to cover his medical expenses for a work-related saw injury. The alleged injury in this lawsuit, however, is overbilling for medical care, not the on-the-job saw injury Hales sustained in 2000. Missouri Baptist and BJC are not alleged to have caused Hales' saw injury. Thus, the insurance money paid by the workers' compensation carrier here was not paid to cover losses due to alleged overbilling, but rather to cover health care for a work-related physical injury for which Mr. Hales himself could not be charged precisely because it was work-related. The money paid by the workers' compensation carrier was not paid to Mr. Hales or on his behalf *as a result of* the defendants' alleged overbilling, which is what the collateral source rule is designed to exclude. The collateral source rule simply has no application to this case.

**iv. Appellants Erroneously Argue Rule 74.04 Precludes
Consideration of The Insurance Payments or
Adjustments When Adjudicating A Motion for
Summary Judgment**

Because the collateral source rule has no application to this case, Appellants' argument that the circuit court improperly relied on inadmissible evidence (i.e., the "collateral source" of payment of the charges by insurance) when concluding Appellants had suffered no damages is misplaced. (*See* Substitute Brief of Appellants, p. 27). As was shown and discussed at length *supra*, the workers' compensation insurance payments made by Hales' employer for the work-related health care at Missouri Baptist are not "collateral sources" to the improper billing "injury" alleged in this case. Thus, Rule 74.04's prohibition on the use of inadmissible evidence when considering a motion for summary judgment is inapplicable. The evidence that workers' compensation insurance paid the work-related health care charges is not inadmissible by virtue of that collateral source rule and, therefore, consideration of that evidence was not prohibited by Rule 74.04.

On page 28 of their Substitute Brief, Appellants also mischaracterize the basis for the circuit court's order. Appellants contend the court's determination that Appellants sustained no damages "rests entirely upon" the insurance

payments. (Substitute Brief of Appellants, p. 28)(emphasis in original). This is simply not true. The circuit court analyzed the damages issues in terms of the individual Appellants and what they paid (nothing in Mr. Hales' case) and what they became financially responsible for even if not paid by them (again, nothing in Mr. Hales' case). (*See* L.F. 1263-1265). In no way can it be said that the circuit court's opinion rested entirely upon insurance payments.

**v. The Benefit of the Bargain Rule Is Inapplicable In
This “No Loss” Case**

As is the case with the collateral source rule, the benefit of the bargain rule of damages is inapplicable in this case because, by operation of the Worker's Compensation Law, Mr. Hales suffered no loss. Nor did he have any legal obligation to pay for, or actually pay for, the Missouri Baptist health care he received. For all the reasons set forth in the facts and argument above, the benefit of the bargain concept simply does not apply or help Hales here.

There can be no proper benefit of the bargain damages here because Mr. Hales did not suffer a loss, as we have seen. Were we to try to undertake a benefit of the bargain assessment, we must still ask the questions: 1) what was the bargain?; and, 2) what was the benefit of that bargain? As to the first question, we need to identify the damage or loss in order to know what Mr. Hales was being protected against by entering into his “bargain.” Here, Appellant Hales seeks to

recover the dollar amount allegedly overcharged for the Missouri Baptist health care. It is clear that Mr. Hales did not enter into any bargain with anyone for a collateral payment to reimburse him in the event his health care was inflated by overbilling.

Appellants, before the Circuit Court and the Court of Appeals, argued that Mr. Hales had two “bargains”: (1) with his employer for the health care he received; and, (2) that he bargained with Missouri Baptist for his health care. Hales’ claim that he bargained with his employer for his worker’s compensation health care insurance is baseless. He did not, nor is there any evidence that he did. No one is claiming that Hales bargained for worker’s compensation insurance as a condition of his employment. Such a position would be absurd because providing the work-related injury insurance is a legal obligation imposed on the employer. §287.140, RSMo. Mr. Hales did not “buy” the workers’ compensation insurance here, making the insurance not something he bargained for at all. This is also the reason Appellants’ policy argument at p. 19 of their Substitute Brief – that the collateral source rule expresses a policy of encouraging citizens to buy and maintain insurance – actually underscores why the collateral source rule (and the benefit of the bargain rule) do not fit the factual mold of this case.

As to any so-called “bargain” with Missouri Baptist, it is a non-sequitur in this case. Whatever arrangement Hales had, or claims to have had, with Missouri

Baptist would extend only to the specific care and its quality (i.e., was he provided something less than he bargained to receive?). That is not the kind of arrangement for a source of reimbursement of loss that is at the core of a benefit of the bargain scenario.

The second question of “what is the benefit,” seems impossible to answer because there is no bargain for the damage alleged – that is, for alleged overbilling for health care. As to the potential benefit, though, Appellants’ billing/coding expert, Dr. Janevicius, candidly testified he had no opinion as to whether Hales had suffered any financial damages as the result of what he described as overbilling. (*See* Subsection (C)(2), *supra*). So, Hales has not demonstrated that any event occurred that would even implicate any bargain which could be considered to be for his protection – his own expert was not able to ascertain any loss for him. Of course, Mr. Hales also testified he was not suing to recover money on his own behalf or for anyone else. (L.F. 209, pp. 46:21-24).

Thus, any attempt to use the benefit of the bargain concept fails because the facts which cause it to properly operate to protect someone who has suffered a loss and made arrangements with a third party to mitigate that loss are simply not present.

4. **Appellant Hales has not suffered an “ascertainable loss” as that term is used in the context of the Missouri Merchandising Practices Act.**

Appellant Hales asserts he suffered damages compensable under the Missouri Merchandising Practices Act because he “paid” for the medical services provided by Missouri Baptist through the assignment to Respondents of benefits otherwise payable to Appellant pursuant to an insurance policy which was provided to him by his employer in return for his labor. (Substitute Brief of Appellants, pp. 33-34). Appellants’ argument again misses the mark. Although medical care can be a “purchase” under the Merchandising Practices Act and such “purchase” can be made with monies paid by insurance, that is only half the inquiry. The Act requires both a “purchase” *and* damages. *Freeman Health System v. Wass*, 124 S.W.3d 504, 507 (Mo.App. S.D. 2004). For the reasons discussed at length in this Brief, *supra*, Mr. Hales does not meet the “purchase” prong of the Act. Even if Mr. Hales were correct on the “purchase” prong, he still has not shown he suffered any damages, again, as has been thoroughly discussed above.

A couple of cases Appellants cite and discuss, *Freeman Health System v. Wass* and *Plubell v. Merck & Co., Inc.*, help to illustrate that: (1) Mr. Hales was not damaged under a Merchandising Practices Act theory; and, (2) he did not

suffer an injury-in-fact under any theory. In *Freeman*, 123 S.W.3d 504 (Mo.App. S.D. 2004), the plaintiff health system sued the uninsured Wass for an unpaid bill. Wass counterclaimed under the Merchandising Practices Act and petitioned for class certification. He alleged he and other similarly situated uninsured patients were unfairly charged in amounts higher than the usual and customary charges for such goods and services in the locale. 124 S.W.3d at 505-06. The trial court dismissed the counterclaim, holding Wass had not paid any part of the bill and had not, therefore, “purchased merchandise nor suffered an ascertainable loss of money or property” as required by the Act. *Id.* at 506. Wass appealed.

In affirming the trial court’s dismissal, the appellate court held medical goods and services meet the statutory definition of “merchandise” and that “purchase” is defined in Webster’s as meaning “to obtain by paying money or its equivalent.” *Id.* at 507. The court affirmed the trial court because, although Wass had “purchased” medical goods and services in the sense he had received and could not give back those services, he had not suffered damages because Wass had not paid for those goods and services. Under the Act, “a private cause of action is given only to one who purchases and suffers damage.” *Id.* (quoting *Jackson v. Charlie’s Chevrolet, Inc.*, 664 S.W.2d 675, 677(Mo. App. 1984)).

Following *Wass* is the *Plubell v. Merck & Co., Inc.*, decision, which involved Merck’s sale of the drug, Vioxx. *Plubell v. Merck & Co., Inc.*, 289

S.W.3d 707 (Mo.App. W.D. 2009). The plaintiffs, all of whom had been prescribed Vioxx, sought damages for themselves and those similarly situated as a result of Merck's failure to disclose and active concealment of the drug's risks. *Id.* at 711. They alleged they suffered damages because the product they and other class members purchased was worth less, since it had increased risks, than what they thought they were purchasing based on Merck's representations. *Id.* Merck filed dispositive motions claiming the named plaintiffs could not state a claim under the Merchandising Practices Act because insurance had paid for the drug. *Id.* The trial court denied the Motions and later certified a class consisting of all Missouri residents who purchased Vioxx for personal or family use, and Merck sought and obtained permission to appeal the class certification. *Id.*

On appeal the court held, among other things, that an "ascertainable loss" could be stated despite the fact that insurance had paid for the drug. *Id.* at 715. The court held the plaintiffs stated an objectively ascertainable loss using the benefit of the bargain rule of damages because plaintiffs alleged the product purchased was worth less than the product they thought they had purchased if Merck's representations had been true. *Id.* What the court found dispositive in this Merchandising Practices Act case was not whether insurance did or did not pay for the drug, but rather that the plaintiffs were alleging a difference in what the

drug was actually worth versus what it would have been worth if Merck's representations about risks had been true.

Neither *Wass* nor *Plubell* is of any help to Mr. Hales for the reasons discussed above: (1) Appellant Hales is not out of pocket anything because his health care was paid by his employer's workers' compensation insurance; (2) Appellant Hales did not "incur" or "become liable for" the health care because he was insulated by operation of the workers' compensation law; and, (3) he cannot rely on the benefit of the bargain rule (as the *Plubell* plaintiffs were able to do) because he does not allege and cannot allege that the Missouri Baptist health care he actually received was of lower quality or value than the health care he had been promised. This is absolutely fatal to his Merchandising Practices Act claim, as well as to any other theory he may seek to pursue.

CONCLUSION

The trial court did not err in granting Summary Judgment to Respondent BJC. The undisputed evidence showed that as a function of Missouri's Workers' Compensation Law, Mr. Hales was not legally responsible for the Missouri Baptist health care charges. Further, Mr. Hales suffered no damages or injury-in-fact in that he was never billed for and personally paid nothing for the health care he received at Missouri Baptist on January 25, 2001, more than 11 years ago.

Respondent BJC asks this Court to affirm the trial court's Summary Judgment order in its favor and grant it its costs expended in the defense of this appeal.

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RULE 84.06(c) CERTIFICATE OF COMPLIANCE

The undersigned hereby certifies, pursuant to Supreme Court Rule 84.06(c), that the foregoing Respondent's Brief of BJC Health System contains 12,910 words, exclusive of the appendix, and that counsel relied on the word count of Microsoft Word for Windows, which was used to prepare the brief. Further, counsel certifies that the electronic copies of the foregoing brief have been scanned for viruses and are virus free.

/s/ Paul N. Venker
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PROOF OF SERVICE

A copy of the Respondent's Brief and Respondent's Substitute Separate Appendix were served upon the following this 26th day of September 2012 by way of the Missouri Supreme Court's E-Filing System:

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