05-CV-B
05-EV-A

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01/26/2005 05:04 PM

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cc
Subject Proposed Rule Changes (Civil & Evidence)

To Whom It May Concern:

Please find attached the manuscript entitled PROVING MEDICAL EXPENSES – TIME FOR A CHANGE. This was recently submitted to the *American Journal of Trial Advocacy* for publication in their next edition. In this manuscript, I propose changes to the Federal Rules of Evidence and the Federal Rules of Civil Procedure (in conjunction with changes in Alabama's counterpart rules and substantive law). Would you please forward this manuscript to the appropriate Standing Committees, Civil and Evidence? (I tried my first jury case in U.S. District Court in 1978, and have extensive trial and appellate experience.) Thanks!

<<PROVING MEDICAL EXPENSES-4.doc>>

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PROVING MEDICAL EXPENSES – TIME FOR A CHANGE

by

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I. Current Medical and Legal Procedures

Current legal procedures and practices for proving medical bills and expenses in tort cases typically involve obtaining testimony from treating physicians concerning the necessity and reasonableness of healthcare

charges.[1] The decision for the trier of fact is stated in the pattern jury charge:

> The measure of damages for medical expenses is all reasonable expenses necessarily incurred for doctors' and medical bills which the plaintiff has paid or become obligated to pay [and the amount of the reasonable expenses of medical care, treatment and services reasonably certain to be required in the future]. The reasonableness of, and the necessity for, such expenses are matters for your determination from the evidence. APJI – 11.09 – Personal Injury – Medical Expenses.[2]

Increasingly, due to the complexity of medical billing and reimbursement procedures, the treating physicians do not know whether and to what extent their own and the hospital's billed or paid charges are reasonable in amount. At their depositions, even excellent doctors frequently express ignorance of medical billing procedures, because coding and billing are typically handled by others. A bewildering number of methodologies, agreements, regulations, statutes, limitations, schedules, accounting systems, software, review policies, reports, and practices control

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[1] James G. Bodin, Authentication, Foundation, Reasonableness and Causation: Admission of Medical Records and the Burdens of Proof in the Injury Case, 64 *Ala. Law.* 382 (2003).

[2] Alabama Pattern Jury Instructions - Civil (2nd Edition), 11.09, West Group, 1993.

coding, billing, and reimbursement for an expanding and diverse range of medical services. [3] Most physicians prefer to concentrate on medical care.

Previously, doctors set their own charges and were familiar with reasonable doctor and hospital charges in their community. Patients used to scrutinize and pay their own healthcare bills before health insurance became widespread, and providers were unlikely to bill unreasonable charges to uninsured individuals. With the advent of specialization, advancements in the type and number of medical procedures, anti-trust concerns, medical management, healthcare insurance, and a host of legal factors affecting bills, billing practices have changed markedly. While doctors still set their own charges, in theory, they are usually no longer reimbursed the amount they charge. It is not unusual, for example, for the health insurer to pay only one-third of the stated charge, and for the balance to be written off. Medical reimbursement is expressed in complicated codes and set by agreements with HMOs, insurance companies, and health care providers in accordance with federal and state regulations, mandatory fee schedules, and a number of

[3] *See, for example,* 42 U.S.C. §§1395 – 1396; Internet Resources for Accurate Coding and Reimbursement Practices, *Journal of the American Health Information Management Association*, http://library.ahima.org.

different reimbursement methodologies. [4] Further, patients today usually leave reimbursement matters up to their carrier.

Coding, reimbursement methodologies, and medical management have reshaped the language and landscape of medical bills. Billed medical treatment is first expressed in diagnosis and medical procedure coding, CPT and ICD codes. ICD (an acronym for International Classification of Disease) codes designate symptoms, injuries, diseases, and conditions. CPT (an acronym for Current Procedural Terminology) codes describe medical, surgical, radiology, laboratory, anesthesiology, and evaluation/management services of physicians, hospitals, and other health care providers. [5] Other specialized codes exist, too. [6] Coders need special training and support, because the changing rules for assigning appropriate codes, and the codes themselves, are very intricate. The Secretary of Health & Human Services is charged with the duty of adopting standards and code sets to facilitate

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[4] Michael K. Beard, The Impact of Changes in Health Care Provider Reimbursement Systems on the Recovery of Damages for Medical Expenses in Personal Injury Suits, 21 *American Journal of Trial Advocacy* 453 (1998) (good discussion of complex changes over the last several decades and technical facets).

[5] Website of American Medical Association, http://www.ama-assn.org/ama/pub/category/3113.html.

[6] Website of U.S. Department of Health & Human Services' Centers for Disease Control and Prevention, http://wonder.cdc.gov/codekit.html.

electronic health care information transactions. [7] ICD codes and CPT codes are the accepted codes for medical billing and reimbursement, but they have undergone enormous changes in recent years and are supplemented with several other codes.

The ICD code, a diagnosis, is supposed to support the CPT code, a medical procedure. Healthcare consulting firms, the government, and insurers have designed software that compares codes for a logical relationship, termed "crosswalks" or "links," between the medical procedure and the diagnosis. [8] Software which compares ICD and CPT codes, and analyzes the relationship, is likely to improve over time. After diagnosis and treatment have been reduced to their respective codes by health care providers, the reimbursement for those items is then subjected to the different reimbursement methodologies used by Medicare, HMOs, Blue Cross, and health insurance carriers. Each payor is entitled to create their own methodology if it complies with all other applicable laws and agreements.

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[7] 42 U.S.C. § 1320d-2.

[8] Website of Wasserman Medical Books and Software, www.crosscoder.com.

Payors of medical charges usually review and audit medical bills and services. [9] Medical bill auditors perform detailed audits, sometimes line-by-line, and report their findings to payors. Mistakes, over-billing, and disallowments are frequently caught, resulting in adjustments to the bill. Utilization review is a review of the medical necessity and appropriateness of medical treatment and services. [10] Prior to audit and review, the charges stated in medical bills are usually reduced through some type of agreement, reimbursement methodology, schedule, or law. Frequently, the difference between the stated charge and the reimbursement rate actually paid is extremely significant. It is therefore increasingly difficult to know what the true charges become after they are reduced by the different reimbursement methodologies, schedules, computer programs, agreements, audits, regulations, adjustments, and pre-determined reimbursement rates. Reimbursement rates for many medical services are a fraction of the stated bill for that same service. Medicare, individual HMOs, and specific carriers each have different reimbursement methodologies and pay different amounts to satisfy the billed charges for designated medical procedures. Medicare and Medicaid play a huge role: a high percentage of total medical costs are

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[9] *See*, Beard, § IV., *supra,* note 4 (good discussion of different managed care reimbursement methods).

[10] *Id.*

incurred caring for older citizens, those federal and state programs increased scrutiny of billed medical charges, and Medicare sets allowable charges. [11] As a practical matter, it matters little what the healthcare provider puts down as a charge, because insurance will only pay so much of the provider's charge; the rest is ordinarily written off as a contractual allowance or adjusted well after the bill has been stated and reimbursement made.

Medical bills themselves have, over the years, become increasingly difficult to read, understand, or interpret. With different methodologies, parallel sets of numbers, discounts, government regulation, cost allocation, different software products, and the application of adjustments at different stages in the entire process (sometimes years after the treatment), the actual bills have become the end products of extremely complex systems.

The subjects of medical charges, medical economics, and healthcare management have become distinct academic disciplines. Most doctors do not have the time required for a full and current understanding of the legal, economic, technical, and business complexities of medical bill coding and payment. Reflecting increased complexity, "Harvard Medical School (HMS) and Harvard Business School (HBS) will launch a five-year joint MD/MBA degree program aimed at producing new generations of leaders

[11] *Id.*

uniquely prepared to face the challenges of an increasingly complex and constantly changing health care environment." [12] The charges coded for each individual component of the total medical services provided to a patient must ordinarily be made by a trained coding clerk, who relies on coding books, support manuals, coding tools, and software products. An example of the increasing complexity is the onerous transition from ICD-9, the 9th Edition of the International Classification of Disease codes, to the improved but significantly modified 10th Edition, ICD-10.

Proving medical expenses as evidence under currently accepted legal procedures involves excessive time, trouble, and expense. "Traps abound." [13] Lawyers face "a myriad of hurdles." [14] Physicians typically charge from $500.00 to $1,500.00, in advance, before they will give deposition testimony, and their testimony often largely recounts what is in the medical records. The court reporter's charges and the attorney time involved in connection with medical depositions add great expense. Medical depositions are often set at very inconvenient times. Additional complications result when plaintiffs see multiple doctors. Frequently,

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[12] Website of Harvard Business School, HBS Press Release, May 6, 2004, www.hbs.edu/about/news/051104_md_mba.html.
[13] 23 AMJUR POF 3d 243, Establishing an Adequate Foundation for Proof of Medical Expenses.
[14] Bodin, *supra*, note 1, 382.

establishing a foundation for the proof of medical bills is secondary to testimony concerning the plaintiff's diagnosis, treatment, suffering, and prognosis. But sometimes lawyers are compelled to depose the principal treating physician for the purposes of proving the necessity and reasonableness of the medical charges. [15] The proof of medical bills through the treating physicians adds time and expense to the deposition process. The paper bills usually reflect both the higher stated charges and the lower reimbursement as to each component of the entire invoice, and it is therefore difficult to redact the bills for trial to show only one set of numbers. Each side seeks to prove different aspects of the same two-headed bills. Sometimes a medical deposition is delayed or prolonged for the time needed to gather needed billing information (which sometimes occurs during the deposition itself). Doctors sometimes awkwardly testify that they are only vaguely familiar with hospital or other charges, and time is consumed qualifying the witness for something the witness is not really qualified to say. At trial, the often boring medical deposition transcript is read to a jury that prefers live witnesses.

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[15] Bodin, *supra*, note 1, at 389 ("The question of reasonable expenses and necessary treatment must be answered through the opinion testimony of an expert witness.").

The requirement of expert testimony from physicians on the subjects of reasonableness and medical necessity makes little sense in a managed care environment. The time and technical clerical activity involved in coding and obtaining payment prevents many doctors from being conversant on the subject. Frequently, after the codes are input into the medical billing system, payment is made by the computer system without any additional human judgment. Federal law strongly encourages, and essentially mandates, the electronic handling of bills in the languages of the ICD and CPT codes. [16] Other traditional aspects of doctors' depositions are also due for modernization and demystification.

Inconsistency in legal treatment, the complications of ERISA,[17] COBRA,[18] HIPPA,[19] and other requirements, all increase uncertainty regarding proof of medical bills. [20] Even worse is asking a witness for testimony the witness cannot truthfully give, and as to one of two sets of

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[16] 42 U.S.C.A. § 1320d-2.

[17] Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §1001, *et seq.*

[18] Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), (Pub.L. 99-272, Apr. 7, 1986, 100 Stat. 82) (codified in 7 different U.S. Code titles).

[19] Health Insurance Portability and Accountability Act of 1996 (HIPPA), Pub.L. 104-191, 110 Stat. 1936, August 21, 1996.

[20] Michael K. Beard, The Impact of Changes in Health Care Provider Reimbursement Systems on the Recovery of Damages for Medical Expenses in Personal Injury Suits, 21 *American Journal of Trial Advocacy* 453 (1998).

charges, that is sometimes the case. The admissibility of the higher stated charges, before they are reduced to conform to the health insurance carrier's or government's schedules, and in the absence of any realistic possibility that the injured party will be asked to pay the difference, does not comply with the long-standing evidentiary predicate of actual payment. [21]

Opposing counsel in tort cases as the law now stands each seek to prove a different facet of the larger body of evidence: Plaintiff's counsel seeks to prove the higher stated charges, and if evidence of reimbursement is admitted, to prove the cost of procuring the coverage and that the plaintiff is obligated to repay the subrogee out of any award. Defense counsel prefer to admit evidence of the lower reimbursement rate, the existence of health coverage, and that the reimbursement satisfies the higher stated charges in full. One side wants the medical bill components to be retail prices, their opponents prefer wholesale prices. While it appears a Request for Admissions would simplify proof, the responder must decide which set of figures will be admitted to and how, so it does not solve the underlying

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[21] *Central of Georgia Railway Co. v. McNab*, 150 Ala. 340, 43 So. 222 (1907) (proof of reasonableness not sufficient without proof of payment); APJI – 11.09 – Personal Injury – Medical Expenses ("which the plaintiff has paid or become obligated to pay").

dichotomy. Nor do many pre-trial orders requiring the exchange of exhibits address or solve the problem. The difficulties and complexities inherent in litigating these factors in isolation have been demonstrated by court decisions and legal scholars. [22] Settlement of injury cases is often slowed until both sets of figures are fully disclosed to both parties. Each side in the meantime has an incentive to push their own set of numbers and downplay the other set, which builds suspicion and delays negotiation. Reactive devaluation has a field day. In truth, these interrelated factors are all part of the larger health care and reimbursement system and should be dealt with as a whole.

From their different perspectives, each side in a personal injury lawsuit has an incentive to prove "payment," which is a required element of proving already-satisfied medical expenses. [23] The required proof of payment necessarily involves proof of the reimbursement amount, unless the

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[22] In *Bruno's Supermarkets, Inc. v. Massey*, 2004 WL 596224 (Ala.Civ.App.) (Blue Cross and Medicare coverage evidence was admitted at trial, but the duty to repay and subrogation evidence was not offered or allowed; a new trial was granted, but on appeal it was held that no new trial should have been allowed); Bodin, *supra*, note 1; Beard, *supra*, note 4.

[23] APJI 11.09; *Central of Georgia Railway Co. v. McNab*, 150 Ala. 340, 43 So. 222 (1907).

courts entertain the legal fiction pursuant to the Collateral Source Rule that the higher stated bills are paid in full. [24]

Alabama Pattern Jury Instruction 11.22 states: "In awarding damages in any case your verdict must not be based on mere speculation or conjecture but must be based upon the evidence and the just and reasonable inferences shown thereby." [25] If the higher stated medical bill, an amount that never was and never will be paid, is admitted without evidence of the lower reimbursement rate, the jury is basing their verdict on "mere speculation or conjecture." [26] The difference between the stated bill and the paid charges (i.e. lower reimbursement rate) is purely fictional as a true charge, and qualifies as speculation by the biller, a conjecture that is not going to hold up once it is reviewed. The difference between the higher billed charges and lower paid charges in this context, when presented as true damages, is false. Ultimately, it is for the jury to determine the credibility of the evidence, including medical bills. [27]

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[24] Under the UCC, "final payment" of negotiable instruments is made by the payor bank, which further points to the reimbursement rate as the truer computation of legal damages. Ala. Code 1975, § 7-4-213.
[25] Alabama Pattern Jury Instructions - Civil (2nd Edition), 11.22, West Group, 1993.
[26] *Id.*
[27] *Id.*, 15.02 – Credibility.

It is illegal for a healthcare provider collecting from Medicare or Medicaid to accept any additional amount for services from any other source.[28] Most HMOs and private carriers and groups have a similar rule: the patient cannot be billed for amounts in excess of the previously agreed-to reimbursed amounts paid to healthcare providers, an uncommon procedure called "balance billing."

Is it just to allow personal injury plaintiffs to claim the excess over reimbursement by presenting to the jury the full stated bill? Presenting such charges to the jury is arguably against public policy, because they represent illusory or illegal charges. Balance billing is allowed in some Private Fee for Services Plans, but the amount billed is still computed as a percentage above Medicare reimbursed amounts. Further, actual payment (or obligation to pay) has always been held a predicate for the recovery of medical bills in tort cases, [29] and the excess in question is never paid. The primacy of actual payment has been widely acknowledged; the Collateral Source Rule does

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[28] 42 U.S.C. §1395cc & §1396a(a)(25)(C); *Ferlisi v. Alabama Medicaid Agency*, 481 So.2d 400 (Ala.Civ.App. 1985); Rules 560-X-6-.01(5) & (6) of the Alabama Administrative Code (1982).

[29] *Central of Georgia Railway Co. v. McNab*, 150 Ala. 340, 43 So. 222 (1907) (proof of reasonableness not sufficient without proof of payment); APJI – 11.09 – Personal Injury – Medical Expenses ("which the plaintiff has paid or become obligated to pay"); *Moorhead v. Crozer Chester Medical Center*, 763 A.2d 376 (Pa. 2000).

not usually allow plaintiffs to recover the unpaid excess over the Medicare, Medicaid, or similar allowances, where that balance would never be paid by the plaintiff or anyone else. [30] But some courts allow the full stated, partially-unpaid charge under the Collateral Source Rule. [31]

Current practice requires physicians to spend time answering or attempting to answer talismanic questions believed necessary to prove two elements of the plaintiff's claim for medical expenses, necessity of the treatment and reasonableness of the charges for that treatment. This structured format can then launch debate at the deposition about many aspects of managed care, wherein the doctor explains his or her sometimes limited knowledge of complicated accounting and coding procedures. [32] Doctors feel compelled to testify at the behest of their patient's personal injury attorney, who in turn seeks what the attorney regards as a required technicality, and perhaps something that must be done to avoid legal malpractice. Doctors obviously have a vested interest in seeing that their

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[30] *Moorehead v. Crozer Chester Medical Center*, 564 Pa. 156, 765 A.2d 786 (2001); *Bates v. Hogg*, 22 Kan.App.2d 702, 921 P.2d 249 (1996); *Hanif v. Housing Authority of Yolo County*, 200 Cal.App. 3d 635, 246 Cal.Rptr. 192 (1988).

[31] *Arthur v. Catour*, 345 Ill.App.3d 804, 803 N.E.2d 647, 281 Ill. Dec. 243 (2004) (Presiding Justice Holdridge, in dissent, insisted on the requirement of actual payment or obligation to pay).

[32] Beard, *supra*, note 4.

charges are upheld and paid. It is a rare doctor who summons the courage to testify that the stated bills are unreasonable or artificially high, for such would be a self-indictment that they are over-charging (or worse).

Even if doctors have detailed knowledge about their own charges, they are in many cases wholly incapable of giving an opinion concerning the amount of the hospital's separate charges. There are few practical places to which plaintiff's counsel can turn for testimony concerning the reasonableness of the hospital's charges, so the treating physician is usually asked to help overcome this legal technicality. [33] While the doctor's knowledge of his or her own practice and billing may be adequate in some cases, it is difficult for that doctor to possess equivalent knowledge of both the hospital's charges and its reimbursement rates. Hospitals are large institutions, and institutional knowledge tends to be spread out among several individuals or departments within the organization. In addition to the hospital's charges, the doctor is then sometimes asked to render an opinion concerning the ambulance, physical therapy, home nursing, and other charges, which further complicates the case and increases the likelihood that the doctor will not know the customary or reasonable

[33] *Cf. Ex parte University of South Alabama*, 737 So.2d 1049 (Ala. 1999) (testimony of hospital's acting director of business services held sufficient to prove reasonableness).

charges. Medical witnesses can and do "get off the hook" by suggesting that plaintiff's counsel should or must ask the reasonableness questions of those specific providers, but this is wholly impractical. In many cases, it is financially prohibitive to take multiple medical depositions simply to prove the reasonableness of things like ambulance, diagnostic, physical therapy, prostheses, and medical device charges. Doctors may regard billing matters as beneath them, professionally or in practical terms, or above them from a technical or administrative perspective. Increasingly over the last few decades, billing is not what doctors do on any routine basis. People who study, analyze, and review stored computer data are often in a much better position to testify about normal and customary medical expenses than the treating healthcare providers.

Proof of medically-related expenses has never been solely restricted to testimony of the treating physician, even though attorneys invariably "play it safe" by obtaining testimony from the treating physician. [34] Nor can it be

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[34] *Ex parte University of South Alabama*, 737 So.2d 1049 (Ala. 1999) (testimony of hospital's acting director of business services held sufficient to prove reasonableness); *Conner v. Hamlin*, 33 Ala. App. 54, 29 So.2d 570 (1947) (value of medicines held common knowledge); *Conway v. Robinson*, 216 Ala. 495, 113 So. 531 (1927) (reasonableness shown by plaintiff who obtained "cheapest one [attendant] he could get"); *Opelika Coca-Cola Bottling Co. v. McEachern*, 242 Ala. 628, 7 So.2d 570 (1942) (medicine value common knowledge; stated medical bills not common knowledge);

said that proof of reasonableness has always been the most important predicate, because actual payment of medical expenses has been held critical. In *Central of Georgia Railway Co. v. McNab*, [35] the Supreme Court of Alabama held proof of the reasonableness of medical services was not sufficient without proof of payment. In *Birmingham R. Light & Power Co. v. Humphries*, [36] the Supreme Court stated: "The natural order is to prove what the charge is, and then prove whether or not it is reasonable. Mr. Sutherland, in his work on Damages, states that proof of the sum paid is some evidence of the value of the services rendered. 3 *Suth. On Dam.* (2d Ed.) p. 2674, § 1250." [37] Actions have always spoken louder than words, and actual payment has always outranked, in terms of evidence, other evidence of reasonableness. But the payors have changed, for at the start of the 20th century, patients paid their own bills, but at the end of the century, their carriers usually did.

In District Court and Small Claims Court, a personal injury plaintiff under current practice must technically prove the necessity and reasonableness of medical charges, although allowances are made under a

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Birmingham R. Light & Power Co. v. Girod, 164 Ala. 10, 51 So. 242 (1909) (proof of reasonableness not required if bills admitted without objection).
[35] 150 Ala. 340, 43 So. 222 (1907).
[36] 172 Ala. 495, 55 So. 307, 308 (1911).
[37] *Id.*

court-determined monetary threshold by some District Courts. The amounts in controversy in courts of limited jurisdiction frequently do not justify the expense of a costly medical deposition, which includes the physician's time and the court reporter's charges. Further, doctors rarely come to court to testify, and that is the way it should be. Injured parties are thereby in essence deprived of their remedy due to the costs of proving their case.

"The purpose of awarding compensatory damages is to fairly and reasonably compensate the injured party for the loss or injury sustained." [38] The trier of fact determines the amount of damages with the underlying purpose in mind. The first sentence of the medical expense jury charge, APJI 11.09, [39] begs several questions: Which charges are "incurred," the higher stated charges or the amount actually paid through reimbursement? What amount is the plaintiff "obligated to pay?" Is it reasonable to charge an amount the law states is too high or may not be paid? Is it really an "expense" if nobody ever pays that amount? These semantic, esoteric, and technical questions are too time-consuming to discuss in the middle of a trial, because they involve contractual, regulatory, and managerial aspects of

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[38] Alabama Pattern Jury Instructions - Civil (2nd Edition), 11.02 - Compensatory Damages (1st sentence), West Group, 1993.
[39] Alabama Pattern Jury Instructions - Civil (2nd Edition), 11.09 - Personal Injury – Medical Expenses, West Group, 1993, quoted in full, *supra*, note 2.

a complex and ever-changing managed health care system. The second sentence of the medical expense jury charge [40] provides the answer to the questions: The jury decides from the evidence. And the jury should decide, because there is arguably substantial evidence that both the higher stated charge and the lower reimbursement amounts were both "incurred" and that the injured plaintiff is obligated to pay one of the two amounts. Juries usually give most credence to the reimbursement amount, according to experienced judges. Many of the financial documents commonly seen in medical record files require that plaintiffs pay the full stated charges if they do not have health insurance coverage to satisfy those charges. Both sets of figures are arguably admissible, because the charges are mathematically computed with reference to each other, and often in relation to Medicare's allowance, and neither set of charges reflects the entire truth behind the actual cost of medical services. Insured and uninsured patients, private enterprise and the government, charity and accounting write-offs, immediate payments and delayed collections, all contribute to the universe of medical costs.

Trial courts sometimes seek to simplify medical bill issues by obtaining an agreement on one amount. When possible, this does simplify

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[40] *Id.*

trial issues, yet the modern medical billing system defies simplification. Stipulation regarding "the medicals" includes stipulations regarding authenticity, foundation, necessity, reasonableness, and sometimes causation, which in the workers' compensation context involves both legal causation and medical causation. Agreement on one set of numbers now requires the plaintiff to accept the minimum amount, the defendant to accept the maximum, or for them to agreed on a figure. Agreement to the admission of both sets of numbers may be the only practical way under current practice for opposing and stipulating attorneys to each in this context "make reasonable efforts to expedite litigation consistent with the interests of the client." [41] By submitting both sets of figures to the jury, complexity is addressed, the trial expedited, and simplification is left to the trier of fact.

Courts already deal with the proof of medical charges in pre-trial orders, but each court is free to enter its own terms regarding that proof. Some courts will deem as authentic any medical bills exchanged by a certain date, unless there is an objection. Other courts will also deem as reasonable and necessary all medical bills exchanged by a certain date, unless there is an objection. Other courts have no provision whatsoever in their pre-trial order relating to the proof of medical bills (or sometimes have no order at

[41] Rule 3.2, Alabama Rules of Professional Conduct.

all). The trial court always retains great discretion in evidentiary matters, but something this basic ought to have a simpler procedural option.

Under § 12-21-45 of the Code of Alabama, evidence that medical or hospital expenses are to be paid or reimbursed through health insurance coverage is admissible as competent evidence in personal injury and death cases. [42] This places the lower reimbursement rate in evidence, frequently after the plaintiff has proved the higher stated charge. The plaintiff under this same statute is then entitled to introduce evidence of their insurance premium (the cost of obtaining health insurance coverage) and any contractual obligation in the policy to repay health insurance benefits out of

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[42] Ala. Code 1975, §12-21-45, in pertinent part, states:

Evidence that medical or hospital expenses to be paid or reimbursed admissible as competent evidence.

(a) In all civil actions where damages for any medical or hospital expenses are claimed and are legally recoverable for personal injury or death, evidence that the plaintiff's medical or hospital expenses have been or will be paid or reimbursed shall be admissible as competent evidence. In such actions upon admission of evidence respecting reimbursement or payment of medical or hospital expenses, the plaintiff shall be entitled to introduce evidence of the cost of obtaining reimbursement or payment of medical or hospital expenses.

(b) In such civil actions, information respecting such reimbursement or payment obtained or such reimbursement or payment which may be obtained by the plaintiff for medical or hospital expenses shall be subject to discovery.

(c) Upon proof by the plaintiff to the court that the plaintiff is obligated to repay the medical or hospital expenses which have been or will be paid or reimbursed, evidence relating to such reimbursement or payment shall be admissible.

any judgment, the legal process of "subrogation." [43] Section 12-21-45 contemplates the admissibility of both sets of figures in a structured order, but does so in the context of the Collateral Source Rule and subrogation principals, and not by directly acknowledging the full complexity of managed medical care. The Collateral Source Rule and subrogation principals are legal principals which do not explain the full economic realities governing medical charges.

II. Proposed Changes

It is proposed that the courts (through pre-trial order, rule, or substantive law) accept as *prima facie* evidence of reasonableness, without requiring expert testimony, the amount of actual payments by commercial health insurers, Medicare, HMO's, Blue Cross organizations, and other sophisticated payors. It is further proposed that the necessity of medical treatment be presumed, and the reimbursed charges deemed admissible, if (1) payment has been made; (2) there is no contrary medical testimony; and (3) there is substantial evidence, based on the type of injury or condition and the treatment provided, that the treatment was necessary, as a matter of common knowledge or according to the medical records, from the

[43] *Id.*

perspective of the court or jury. Together, these changes would reduce or shorten medical depositions, and in some cases eliminate them altogether, yet preserve the right of any party to take medical depositions.[44] The evidence submitted under these proposed changes would be subject to impeachment, contradiction, medical testimony, and all other currently admissible evidence on the topic of the medical procedures, charges, and payments. The trier of fact would continue to make the ultimate decisions concerning the necessity, reasonableness, and causation regarding medical bills and expenses. Parties could still question the accuracy of all coding, billing, math, fraud, overcharging, interrelatedness with other treatments and conditions, and all mistakes, misprints, or errors. Under current practice, juries are allowed to make determinations concerning the medical necessity of treatments. "When medical bills are admitted into evidence, the jury is free to conclude that some or all of the bills were unnecessary." [45] A jury may also conclude in terms of causation that the charges were not incurred

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[44] The author believes these proposals would be advantageous in most American courts. *See, Annotation*, 12 ALR 3d 1347, Necessity and sufficiency, in personal injury or death action, of evidence as to reasonableness of amount charged or paid for accrued medical, nursing, or hospital expenses (1967); 23 AMJUR POF 3d 243, Establishing an Adequate Foundation for Proof of Medical Expenses; Beard, *supra*, note 4.

[45] *Savoy v. Watson*, 852 So.2d 137, 140 (Ala.Civ.App. 2002).

as a result of the defendant's negligence. [46] The presumptions of necessity and reasonableness would be most appropriate in the simpler scenarios (i.e. otherwise healthy plaintiff, injured in accident, taken to Emergency Room in an ambulance, broken bones from the accident treated at hospital and in follow-up visits to doctors). In more complicated scenarios, such as where the mechanics of injury or diagnosis are accompanied by pre-existing or unrelated medical conditions, the presumptions might be less appropriate as to some or all of the medical bills.

The number and length of medical depositions could be further reduced by the simple expedients of (1) allowing the parties and court to read medical definitions to the jury from a good medical dictionary, and (2) providing the jury with the physician's official qualifications, which are available through on-line verification systems. [47]

Proof of both the higher and lower amounts is permitted in Alabama personal injury and death cases, and either can provide the basis for an award according to the Supreme Court of Alabama, although the common

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[46] *Id.*

[47] Medical Licensure Commission of Alabama, License Verification, www.albme.org/verification.htm; Administrators-in-Medicine DocFinder (www.docboard.org); American Board of Medical Specialties (www.abms.org).

law in this field is still evolving. [48] In *Marsh v. Green,* [49] and *Mobile Infirmary Medical Center v. Hodgen,* [50] the Supreme Court of Alabama re-thought its former criticism of § 12-21-45. In 1996, § 12-21-45 was viewed as an "apparent attempt to change the law of evidence without expressing the effect on the law of damages." [51] Now:

> This silence can be viewed as a virtue, not a vice, because it leaves to the courts their historical function of determining the limits of recoverable damages, through an evolving common law. This statutory silence gives both a plaintiff and a defendant latitude to explore various arguments about windfalls. A defendant may desire to argue that reimbursement of the plaintiff for medical expenses already paid by an insurer is a double recovery. On the other hand, a plaintiff may wish to argue that the defendant reaps a windfall unless additional damages are awarded, beyond the mere expense of the insurance or other collateral-source benefits, so as to compensate the plaintiff for having the discipline and foresight to devote money or earning power to paying the expense of acquiring the insurance or other collateral-source benefits rather than paying for some immediate gratification. Any review of matters concerning the validity or permissible effect of such arguments must await a proper case. A verdict form dealing specifically with collateral-source reimbursement would facilitate such a review. [52]

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[48] *Marsh v. Green*, 782 So.2d 223, 233, n.2 (Ala. 2000), quoted in *Mobile Infirmary Medical Center, supra*, at 23.
[49] 782 So.2d 223 (Ala. 2000).
[50] 2003 WL 22463340 (Ala.).
[51] *American Legion Post No. 57 v. Leahey*, 681 So.2d 1337, 1346 (Ala. 1996).
[52] *Marsh v. Green*, 782 So.2d 223, 233, n.2 (Ala. 2000), quoted in *Mobile Infirmary Medical Center, supra*, note 50, at 23.

Methods of proof are generally cumulative, adding flexibility to the legal system. Ala. Code (1975), §12-21-10 provides:

> **Division cumulative as to proof of documents or records.**
>
> The mode or manner of authenticating or proving any documents or records provided for in this division shall not be held to be exclusive or restrictive, but shall be additional or cumulative modes or manners of authentication or proof of such records and documents. *(Code 1923, §7718; Code 1940, T. 7, §431.)* [53]

If the computer world has taught us anything, it has taught us that providing at least two ways to perform a function is less frustrating and faster than mandating a single method. Modern medical billing is too complicated for a narrow, cookie-cutter approach. The trier of fact must be allowed to see more of the whole picture.

Additional language could be given after the existing language of APJI 11.09 - Damages – Personal Injury – Medical Expenses, [54] as follows:

> In this case, the parties have introduced evidence of stated healthcare charges, the amount actually paid by plaintiff's health insurance carrier to fully satisfy those charges, plaintiff's insurance premiums, and the requirement that plaintiff repay his or her carrier if plaintiff receives a judgment in this case. You are entitled to consider all of these factors in arriving at a determination of any damages for medical expenses. [Possible "collateral source" option adds: You may in your sole discretion determine if defendant should

[53] Ala. Code 1975, §12-21-10.

[54] Alabama Pattern Jury Instructions - Civil (2nd Edition), 11.09, West Group, 1993.

benefit by any bill reductions obtained by having health care coverage.]

The Federal [55] and Alabama [56] Rules of Evidence could be expanded, or pre-trial orders could be drawn, to include language substantially as follows:

> Reimbursed hospital, medical, doctor, and other healthcare expenses, paid by any reviewing health insurance carrier, trust, HMO, government agency, or similar entity subjecting said expenses to substantial scrutiny, audit, or review, shall be presumed reasonable in amount, without the necessity of expert or other testimony as to the reasonableness of the amounts reimbursed. Upon the admission of said reimbursement evidence or records, the original stated charges that any reimbursement fully satisfied may also be admitted without expert or other testimony, in the same manner, with the stipulation, if it be a fact, that the reimbursement satisfied the higher stated charges in full, that the plaintiff will not be "balanced billed" for the difference, and that the plaintiff is obligated to repay the payor out of any award, but only if an award is made.
>
> Said reimbursed charges or expenses may be admitted without the necessity of testimony as to their medical necessity if (1) there is any substantial evidence or inference that the charges were incurred as a result of the accident or incident complained of, and (2) an opposing party, who is prepared to offer evidence contrary to their medical necessity, has not specifically objected to their admissibility in a timely manner.
>
> All parties may contradict with evidence or argue against the reasonableness and necessity of the admitted evidence, or any part thereof, even if they agree to the admission of the charges without objection.

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[55] Federal Rules of Evidence.

[56] Alabama Rules of Evidence, adopted effective January 1, 1996, found in Alabama Rules of Court – State, Thompson – West.

The law should encourage early disclosure of all numbers, summaries, itemizations, amounts, and calculations concerning medical charges, because the actual bills are frequently difficult to interpret. Too often, settlements are delayed because the reimbursement rate, in the form of a "subrogation amount" or "lien amount," has not been determined or obtained by both parties. If the patient is still being treated at the time the lawsuit is filed, this important number will not yet be final. Often the plaintiff negotiates with the carrier to obtain a reduction of this subrogation interest, and the defendant is usually "out of the loop" regarding the status of these negotiations. Once the subrogation interest has been stated in writing by the carrier, in final or temporary form, a duty of full disclosure, by rule or pre-trial order, should require that all parties be provided with the subrogation statement (1) by the subrogating "non-party" carrier or (2) any party obtaining or calculating this information. Rule 26(a) of the Federal Rules of Civil Procedure [57] ought to be amended to specifically require the disclosure of this information when it is obtained and a similar rule in state court would assist trial preparation and settlement. The formal disclosure of this amount would promote the admissibility of the subrogation interest, better reconcile the subrogation interest with the real party in interest rule, and allow the

[57] Federal Rules of Civil Procedure, Rule 26(a).

carrier to stay away from the courthouse while preserving the right of subrogation. A procedure in the form of federal and state statutes might require all subrogees, when requested by any party, to file their claims in individual cases on pain of a "failure to prosecute" or Rule 17(a) dismissal of their subrogation claims.

III. Advantages of Proposed Changes

Advantages for all parties would result from the addition of a more modern procedure, not to replace but to supplement current practice in personal injury and death cases. It is not suggested that current practices be eliminated, since practical experience must shed light upon the proposed changes before those changes are fully accepted in the legal and medical communities and unforeseen consequences can arise.

Advantages for Plaintiffs. Plaintiffs and their attorneys in personal injury cases would benefit from an additional method of proving medical expenses. The costs associated with deposing doctors would in some cases be eliminated and in many cases reduced. In most cases, the time needed to depose a doctor will be reduced by the time needed to prove the reasonableness of medical bills. Even in those cases where plaintiff's counsel would prefer to depose the doctor, the doctor's deposition would

often not be a mandatory predicate for trial readiness or the serious settlement negotiations that grow from trial readiness. The doctor's deposition under current practice is often regarded as necessary to "prove the medicals." In some cases, defendants rest easy knowing that the doctor's deposition has not yet been taken, that therefore the plaintiff is not ready for trial, and that the defendant is not yet under immediate pressure to settle.

Advantages for Defendants. Defendants in personal injury cases would benefit from the same reduction of litigation costs associated with the proposed changes. Defendants would further benefit by proof of lower reimbursement rates, which will often be given more credence by the jury than the artificially higher stated bills. Collateral sources would obtain relevancy as rebuttal of plaintiff's damages claim, in addition to the current statutory abrogation of the Collateral Source Rule under §12-21-45. [58]

Advantages for the Medical Profession. The medical profession would benefit from shortened deposition time, thus allowing physicians to focus on their primary mission of patient care. The awkward aspects of medical depositions, wherein the doctor professes ignorance of various charges and billing practices, or feigns knowledge that the doctor does not

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[58] Ala. Code 1975, §12-21-45, *supra*, note 42.

really have, would be reduced or eliminated. Most doctors would prefer not to give depositions or to minimize the amount of time they have to spend in them. The proposed changes would result in medical depositions focusing more exclusively on the patient, and less on accounting. Doctor's depositions will still be sought to prove other aspects of the personal injury claim, but in some cases, the need for them will be eliminated. Medical depositions will always be desirable to prove the full extent, details, and consequences of injuries, treatments, and recoveries; and to prove that a particular trauma caused the injuries, treatments, and conditions at issue. If fully descriptive medical records eliminate the need for a deposition, then healthcare providers might have an incentive to prepare more detailed, descriptive, and readable records.

New federal privacy regulations complicate release of medical information, further complicating depositions and adding to legal system complexity and cost. [59] 45 C.F.R. §164.512(e)(1) was promulgated pursuant to HIPPA, Health Insurance Portability and Accountability Act of 1996, and typically requires a "HIPPA order" from the court, despite existing and equivalent safeguards under Rule 45, Ala.R.Civ.P. & Rule 45, Fed.R.Civ.P.

[59] 45 C.F.R. §164.512(e)(1).

[60] Anti-trust laws prevent doctors from conspiring to set fees, and mere knowledge of other doctor's fees could be evidence of anti-competitive activities; hence the conflict between anti-trust provisions and the doctors knowing "usual and customary" fees for the purpose of proving medical expenses. ERISA-preemption imposes its own additional layer of federal involvement and complexity. [61] Reducing system complexity in both the medical and legal contexts benefits society as a whole.

Advantages for the Judicial System. The judicial system would benefit by faster trial preparation and increased flexibility. The inability to depose a certain doctor, for example, would not require as many continuances or delays in case evaluation. Fewer trial subpoenas would be issued. Evidentiary rulings and jury verdicts would be more readily supported with the additional procedure in place, especially if either set of numbers could provide the basis for an award. Increased use of District Court would make the legal system faster and more efficient.

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[60] 45 C.F.R. §164.512(e)(1) was promulgated pursuant to HIPPA, Health Insurance Portability and Accountability Act of 1996, Pub.L. 104-191, 110 Stat. 1936, August 21, 1996. Ala.R.Civ.P. 45 – Subpoena; F.R.Civ.P. 45 – Subpoena.

[61] Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §1001, *et seq.*

In District Court and Small Claims Court, a personal injury plaintiff under current practice must usually prove the necessity and reasonableness of medical bills.[62] The amounts in controversy in courts of limited jurisdiction unfortunately sometimes do not justify the expense of a costly medical deposition, which includes the physician's time and the court reporter's charges. [63] The high cost of medical depositions, together with outmoded procedures for proving medical bills, essentially denies personal injury plaintiffs one of their remedies. [64]

Adopting these changes first in state District Court would provide immediate reform where it is perhaps most needed, in both tort and contract cases. Experience in courts of limited jurisdiction might provide useful experience for the same changes in general trial courts. Relaxing the burden of proof in District Court *only* would encourage personal injury plaintiffs to file their cases in District Court.[65] Many cases filed in Circuit Court are settled within the jurisdictional limits of state District Court, indicating an untapped potential for increased efficiency through use of bench trials.

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[62] Some District Courts make allowances for smaller cases.
[63] The jurisdictional limit of District Court (which includes Small Claims Court) is $10,000.00. Ala. Code 1975, §12-12-30.
[64] *See,* Ala. Constit. (1901), § 10 (Right to prosecute civil cause.) & §13 ("every person . . shall have a remedy by due process of law").
[65] The time consuming, more expensive, and slower general trial docket is one of the principal timeliness concerns of judicial systems.

Alabama's Collateral Source Rule, and its abrogation by statute, are considered substantive law by the 11th Circuit, and therefore applicable in diversity cases in U.S. District Court. [66] These proposed changes would prove beneficial in most American courts, federal and state.

Advantages for Healthcare Insurers. When healthcare insurers are entitled to the recovery of medical expenses, they are at that point, to the extent of their payment, real parties in interest. Rule 17(a) of both the Federal & Alabama Rules of Civil Procedure provides that "Every action shall be prosecuted in the name of the real party in interest." [67] Revealing the stake of the real party in interest is therefore not just admissible under § 12-21-45 of the Code of Alabama, which abrogates most of the Collateral Source Rule, but also from a procedural basis under Rule 17. [68] The status of the carrier as a real party in interest is not negated by contractual language requiring the insured to repay the carrier out of any recovery and relieving the carrier of the need to intervene in any lawsuit, because such provisions do not erase the interest of the carrier in the outcome of the litigation. The proposed procedures allow the subrogation interest of the carrier to be

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[66] *Bradford v. Bruno's, Inc.*, 94 F.3d 621 (11th Cir. 1996).
[67] F.R.Civ.P. 17(a); Ala.R.Civ.P. 17(a).
[68] Ala. Code 1975, § 12-21-45, *supra*, note 42; Ala.R.Civ.P. 17.

directly addressed and fully disclosed, without the necessity of motions to add the real party in interest or debate the issue.

Advantages in Creditor-Debtor Cases. Suits against uninsured debtors to collect hospital bills pose some of the same issues present in tort cases, although the contractual relationship imposes different considerations and law. Allowing medical providers the option to prove their usual reimbursement without any additional testimony would constitute an advantage for creditors in some circumstances, and it would in those same cases afford the defending debtor a significant monetary advantage not bargained or paid for by the debtor. Charging uninsured patients the full stated charge becomes less defensible when the sometimes shocking disparity between the stated and commonly reimbursed charges grows.[69]

IV. Justification Under Current Law

Evidentiary rules should "be construed to secure fairness in administration, elimination of unjustifiable expense and delay, and promotion of growth and development of the law of evidence to the end that

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[69] The average disparity between the stated and reimbursed charges varies from state to state. The greater the disparity, the greater the need for reform. The legal resolution of other creditor-debtor issues in the medical bill context is outside the scope of this article.

the truth may be ascertained and proceedings justly determined." [70] Procedural rules should "be construed and administered to secure the just, speedy and inexpensive determination of every action." [71] As legal system complexity and costs rise over time, a reversion to simplicity and uniformity makes sense.

Under Ala. Code §12-21-45, evidence in personal injury and death cases that medical or hospital expenses are to be paid or reimbursed is admissible as competent evidence. [72] Medical bills are not carved in stone. The trier of facts always retains power to decide necessity, reasonableness, and causation. "The necessity and reasonableness of medical expenses is a jury question, and the jury is not obligated to award medical expenses simply because they were incurred." [73] Because jury verdicts often exceed the medical bills by a wide margin, or are for the defendant, the issue is not often a problem on appeal. Inconsistent or inadequate verdicts arise when verdicts for the plaintiff do not include proven medical bills. [74] Allowing

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[70] Fed.R.Evid 102; Ala.R.Evid. 102.
[71] Fed.R.Civ.P. 1; Ala.R.Civ.P. 1(c).
[72] *Marsh v. Green*, 782 So.2d 223 (Ala. 2000) (§12-21-45 found constitutional, after previously being found unconstitutional).
[73] *Lynch v. Rowser*, 597 So.2d 227, 229 (Ala.Civ.App. 1992).
[74] *Clark v. Black*, 630 So.2d 1012 (Ala. 1994) (jury bound to award amount of medical bills if liability determined for plaintiff and stipulated medical bills admitted without objection).

either set of numbers to support a jury award would lessen the number of inadequate verdicts, because the verdict would then more often be supported by the fairly wide numeric range encompassing the two different sets of numbers.

The reimbursement rate is already admissible several different ways under §12-21-45 [75] and common law. First, it is "evidence respecting reimbursement." [76] Second, because the reimbursement rate determines the amount the plaintiff is obligated to repay in the event of an award, it is "evidence relating to such reimbursement" in connection with the plaintiff's duty to repay. [77] Third, it is evidence of actual payment under the long-standing predicate requiring same. Lastly, it is evidence of the identity of the real party in interest.

Payment itself, now made by carriers, is admissible under long-standing law holding that if the subject is a matter of common knowledge, payment of medical expenses is some proof of their reasonableness. [78]

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[75] Ala. Code 1975, § 12-21-45, *supra*, note 42.
[76] Ala. Code 1975, § 12-21-45(a), *supra*, note 42.
[77] Ala. Code 1975, § 12-21-45(c), *supra*, note 42.
[78] *Foodtown Stores, Inc. v. Patterson*, 282 Ala. 477, 213 So.2d 211 (1968); *Birmingham Amusement Co. v. Norris*, 216 Ala. 138, 112 So. 633 (1927); *Birmingham R. Light & Power Co. v. Humphries*, 172 Ala. 495, 55 So. 307 (1911).

When the Collateral Source Rule shielded evidence of payment, it was difficult for the plaintiff to prove payment of the stated bills, especially after they had been reduced. Clearly, the Collateral Source Rule, if applied, now stands in the way of the truth more than it ever has, because it purports to conceal not just reimbursement, but the additional evidence of bill reduction, complicated systems leading to discounts, subrogation, premium payment, and the identity of the real party in interest. The modern billing regime does not lessen the importance of actual payment as a check and balance on medical bill claims, but, in most instances, changes the identity of the payor.

Adopting reimbursement or paid charges as the best proof of the reasonableness of a medical bill makes more sense than asking that question of a physician who is focused on medicine. Health insurance carriers, HMOs, Blue Cross, and other payers do not often pay unreasonable bills, and neither did uninsured individuals at the start of the 20th century. At the least, the presumption should be that the carrier's payments are reasonable in amount for the stated services rendered. The legal requirement to prove reasonableness is a check and balance on the billing process, to make sure claimed charges are not too high. The checks and balances rest today, not primarily in the minds and testimony of physicians, but in methodologies, insurance audits, laws, medical management, payment schedules, and

software. A knowingly false Medicare or Medicaid claim by a healthcare provider is a felony.[79] The reasonableness of medical bills and services is determined by the system, not an individual.

Existing evidentiary law concerning proof of commercial rates sanctions reference to pre-determined prices and deference to the opinions of those who really know the value of an item. Section 12-21-114 of the Code of Alabama states: "Direct testimony as to the market value is in the nature of opinion evidence; one need not be an expert or dealer in the article, but may testify as to value if he has had an opportunity for forming a correct opinion." [80] Under §12-21-113 of the Code of Alabama, in effect since 1852, "price current" and commercial lists, printed at any commercial mart, are presumptive evidence of the value of any article of merchandise specified therein, at that place, at the date thereof and of the rate of exchange between that and other places, also of the rates of insurance, freights and the times of arrival and departure of ships and other vessels." [81] The commercial lists applicable to modern medical charges are active databases. Fed.R.Evid. 803(6) & Ala.R.Evid. 803(6), Records of Regularly Conducted Activity, and Fed.R.Evid. 803 (17) & Ala.R.Evid. 803 (17), **Market**

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[79] 18 U.S.C. § 287.
[80] Ala. Code 1975, § 12-21-114.
[81] Ala. Code 1975, §12-21-113.

Reports, Commercial Publications, indicate that catalogue prices, are admissible as exceptions to the hearsay rule. [82] Federal and Alabama Rules of Evidence 803 (4) & (6) specifically exempt statements for purposes of medical diagnosis and records of diagnoses from the hearsay rule. [83] Ala. & Fed. R. Evid. 901(b)(7), *Public Records or Reports*, dealing with authentication of documents, offers additional credibility to the admissibility of insurance-reimbursed medical bills without the necessity of expert testimony. [84] With due respect to the professionalism of the medical profession, the billing procedures imposed by powerful forces have transformed the medical profession's prices into a form very similar to the commercial lists or current prices referred to in the old statute. Opinion testimony from doctors is now less valuable than documents derived from structured, computerized methodologies. Computer programs and databases hold the ultimate knowledge, and can also calculate, bundle, un-bundle, confirm, audit, and review thousands of different medical charges.

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[82] Fed. R. Evid. 803(6) & Ala. R. Evid. 803(6), Records of Regularly Conducted Activity; & Fed.R.Evid. 803 (17) & Ala.R.Evid. 803 (17), Market Reports, Commercial Publications.
[83] Fed.R.Evid. 803 (4) & (6); Ala.R.Evid. 803 (4) & (6).
[84] Fed.R.Evid. 901(b)(7) & Ala.R.Evid 901 (b)(7), *Public Records or Reports*.

Fed.R.Evid. 902 (5) & Ala.R.Evid. 902 (5), **Official Publications**, makes publications issued by public authorities self-authenticating. [85] Documents in the departments of the United States government may be proven by the certificate of the legal custodian thereof.[86] Medicare reimbursement rates might be considered government documents and the law. What the doctor "charges" approaches the irrelevant, because the charge is satisfied in most cases with a set amount outside the immediate control of the doctor or hospital. The doctor's knowledge of hospital, ambulance, and physical therapy charges, as opposed to his or her own bill, is even less. Government regulation, payment schedules, software, codes, and negotiated reimbursement arrangements, in effect make most medical charges "catalogue prices" at the time they are rendered. Such prices could be deemed admissible simply based on the acknowledgement that almost all healthcare providers are receiving the same amount for the same service, at least with regard to patients under the same health plan or government regulation.

Judicial decisions rendered before detailed medical management of healthcare charges were not wrongly decided. The modern healthcare

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[85] Fed.R.Evid. 902 (5) & Ala.R.Evid. 902 (5), *Official Publications*.
[86] Ala. Code 1975, §12-21-73.

system creates different evidence, payors, and scrutiny. Modern medical bills arguably speak with a forked tongue -- or at least have two heads. Proof of necessity, reasonableness, and payment should always be basic elements of proving medical bills, [87] although not necessarily in advance of their admission. [88] In *Aplin v. Dean*, [89] it was stated:

> If, after proving the amount of the charge, the plaintiff should fail to offer any evidence tending to show hospitalization was necessary, and the charge to be reasonable, the defendant should either move for the exclusion of the testimony as to the charge or bill, at the close of the evidence, or should ask for an affirmative instruction against recovery in that behalf, as in other cases of failure of proof. [90]

The point is that the two elements of necessity and reasonableness are processed in modern times by systems which put medical charges in the designated languages of ICD, CPT, or other codes, route them through computer systems, make payment of pre-determined amounts electronically, and then follow with audits and adjustments. Proof of reasonableness of charges for surgical and medical services are still matters for expert

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[87] *Foodtown Stores, Inc. v. Patterson*, 282 Ala. 477, 213 So.2d 211 (1968).
[88] *Birmingham Railway Light & P. Co. v. Moore*, 148 Ala. 115, 42 So. 1024 (1906).
[89] 231 Ala. 320, 164 So.2d 737 (1935).
[90] *Id.*, at 740.

opinions, as the pre-managed care decisions stated, but modern expertise is issued by the computer systems. [91] The economic power and sophistication of the payers, operating within a legal framework, provide substantial evidence, at least on a *prima facie* basis, of necessity, reasonableness, and payment in most cases.

"The law of Alabama is clear that there must be proof of the reasonableness of expenses which are not of common knowledge."[92] Today, it is common knowledge that the health insurance carriers scrutinize medical bills and reimburse only so much of the stated charges; the review process and subsequent partial reimbursement constitute substantial evidence that the charges are reasonable in amount.

As a result of the financial incentive to over-bill and the ease of billing errors being made, complicated procedures, including federal criminal law, oversee the process to reduce over-billing and mistakes. These systems help keep medical bills reasonable in amount and the provision of medical services necessary. Given this entrenched system of checks and balances, it does not make sense for the heavily scrutinized and discounted

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[91] *Cf. Aetna Life Ins. Co. v. Hare*, 47 Ala. App. 478, 256 So.2d 904 (1972).
[92] *Foodtown Stores, Inc. v. Patterson*, 282 Ala. 477, 483, 213 So.2d 211, 216 (1968).

providers to be giving the primary evidence that their bills are reasonable and necessary, especially the charges they know will never be paid in full. Patients no longer have much individual freedom to bargain for the most reasonable services, since those negotiations are made for them in advance of their need for treatment. Most patients never pay their actual bills, they instead pay their premiums in advance of those bills being created and co-payments. The neighborhood doctor is no longer preparing bills for his friends, patients, and neighbors to pay.

"Damages which are the legal and natural result of the act done, though contingent to some extent, are not too remote to be recovered."[93] The natural result of incurring medical bills is the necessity of payment, not the accumulation of a higher figure that is not legally owed or due to be paid. "If damages are only imaginary or the possible result of a tortuous act, they are too remote to be the basis of recovery." [94] In the normal insured scenario, the excess over the reimbursed amount is imaginary or illusory, and therefore too remote to be recovered. If an injured party voluntarily refused to turn their medical bills over to their insurer, knowing that their insurer could obtain a substantial discount, and voluntarily chose to incur the

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[93] Gamble, *Alabama Law of Damages* (3d ed.), §2-3.
[94] *Id.*

higher amount, then the plaintiff has not mitigated their damages or avoided the consequences of the defendant's negligence. [95] The dichotomy is most evident in the case of the uninsured and penniless: They are charged the most, and obtain zero reductions, but they pay the least (i.e. zero) in the end, unless they have a valuable personal injury claim as a result of the treated injuries.

Each party has the right to cross-examine, impeach, rebut, and contradict evidence and testimony put on by the opposing party. Overcoming the presumption that Medicare, an HMO, or insurance carrier has approved charges is well beyond the type of proof ordinarily offered in rebuttal at the trial of a personal injury suit. The best rebuttal possible to modern stated health care bills is proof of the lower reimbursement rate.

Official acts and governmental facts are proved in several ways. Current medical charges are in many cases set by Medicare or Medicaid regulations, or by the Workers' Compensation Medical Services Board. [96] In essence, modern fee schedules and rates are, in many respects, *the law*, in addition to being evidentiary facts in individual personal injury cases.

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[95] *See, id.*, §2-9.
[96] Ala. Code 1975, § 25-5-313.

Courts are duty-bound to apply the law in individual cases, especially if it is brought to their attention by the parties through their attorneys.

"The life of the law has not been logic; it has been experience." [97] Experience is now paving the way for changes. It is common for opposing lawyers to agree to the admissibility of both sets of medical bill figures. The statutory abrogation of the Collateral Source Rule, the jury's authority to consider of all the evidence, and modern billing and reimbursement procedures, should allow each jury to receive both sets of figures, even if only the lower set of figures is allowable as damages per the court's jury charge. Experience has already shown that juries award the lower reimbursement sums, not the higher stated bills, in most cases.

The strongest argument is that only the lower reimbursement amount should be allowed as an element of damages, even if the jury receives both sets of figures. Sole reliance upon this figure brings up the old rationale for the Collateral Source Rule: Why should the wrongdoer benefit from patient-procured insurance? Patient-procured insurance plays a huge role in obtaining the discounts reflected in the lower reimbursement rate. Without insurance, the patient is charged the higher stated amount, with fewer or no

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[97] Oliver Wendell Holmes, Jr., The Common Law.

reductions. Restricting the evidence to the lower reimbursed amounts would punish those who are responsible enough to obtain medical insurance, and allow the uninsured, who often do not pay their medical bills, to claim higher damages for a given treatment than the insured. Higher stated charges provide a context for the lower reimbursement, and to some extent reflect the costs of treating uninsured and indigent patients and sometimes future adjustments by the health insurance carriers. The jury arguably is entitled to know the financial relationship between healthcare providers and insurance carriers, Medicare, Medicaid, and other guarantors, even if only the reimbursed amount provides the basis for an award. The admissibility of the higher stated bill does not prevent the court from charging the jury that only the amounts actually paid can be awarded to the plaintiff. The Supreme Court of Alabama indicates the "windfall" issue can be argued either way.[98] Some courts allow the full stated, partially-unpaid charge under the Collateral Source Rule. [99] Two-headed medical bills are generated, and two-headed bills are what the jury should see.

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[98] *Marsh v. Green*, 782 So.2d 223, 233, n.2 (Ala. 2000), quoted in *Mobile Infirmary Medical Center*, *supra*, at 23.

[99] *Arthur v. Catour*, 345 Ill.App.3d 804, 803 N.E.2d 647, 281 Ill. Dec. 243 (2004).

Something similar to the Doctrine of Completeness might justify admission of all evidence in the entire systematic process: the existence of coverage, the acquisition of coverage through premium payment, the first statement for medical expenses, payment of a reduced amount by the health carrier, the full satisfaction of the higher stated charges, and finally through the subrogation interest of the carrier requiring repayment by the plaintiff out of any recovery. [100] Each of these factors implicates other related facts; keeping any one of them out of evidence would often be unjust and potentially misleading. The stated charge and the lower reimbursement are often on the same document, and so it is often easier as a practical matter to admit both sets of figures into evidence.

V. Medical Necessity, Causation & Authentication Elements of Proof.

Historically, a cluster of evidentiary predicates have been sought in doctors' depositions. Even if the reasonableness of charges is presumed, other evidentiary hurdles must still be considered, but none of them demonstrate the absolute need to depose the doctor in every lawsuit.

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[100] Fed.R.Evid. 106 & Ala.R.Evid. 106 – Remainder of Writings or Recorded Statements; Ala. Code 1975, § 12-21-45, *supra*, note 42.

Medical Necessity. What of the requirement that the necessity of the treatment also be proven? Does that not mandate medical testimony anyway, generally through a deposition? Not necessarily. In *Posey v. McCray*, [101] it was stated that "the necessity of treatment was evident from the injury." [102] In the discretion of the trial court, it may often be evident that medical treatment, in an amount paid by a scrutinizing health insurance carrier, was necessary. The existence of pre-existing conditions, complex causes, debatable causation, unknown diseases, and the like may make admissibility questionable for the trial court, but in many cases, it will be obvious that medical care was needed for a specific, obvious traumatic injury. The reasonableness of the amount of the bills and the necessity of the treatment by medical doctors can both be presumed evident if a commercial health insurer pays those bills.

Ultimately, the necessity of treatment is a medical question. Very few doctors will testify that the treatment they gave was unnecessary, so the requirement of testimony in this regard is practically meaningless in most instances.

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[101] 594 So.2d 152 (Ala.Civ.App. 1992).
[102] *Id.*, at 154.

Causation. Medical treatment can be necessary for the care of the patient and not be caused by a contested accident. Proof of causation is therefore separate and apart from proving the necessity and reasonableness of medical expenses. Causation questions can remain after establishment of the necessity and reasonableness of medical bills. Payment of medical bills simply has no probative value on the question whether a defendant's actions required plaintiff to need medical treatment. The requirement that doctors testify "to a reasonable degree of medical certainty" is usually seen in causation questions, [103] but the mythic importance surrounding these talismanic words has been refuted. [104] The requirement of proving causation is largely outside the scope of this article, but in many routine and obvious scenarios, this element of proof could be satisfied without medical testimony. No deposition should be necessary to prove that a motor vehicle accident immediately caused broken bones and the resulting surgery.

Authentication & Foundation. Authentication and establishing a foundation are not often practical evidentiary problems with regard to

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[103] *See, for example, Wal-Mart Stores, Inc. v. Kennedy*, 799 So.2d 188 (Ala.Civ.App. 2001).

[104] Bodin, *supra*, note 1, at 388, *citing Western Ry. Of Ala. V. Brown*, 196 So.2d. 392, 400 (Ala. 1967) (the case and scholar state that the somewhat misleading phrase "to a reasonable degree of medical certainty" is legally the same as "preponderance").

medical records and bills. The defendant typically subpoenas the medical records directly from the health care provider, and is then in a position to verify their authenticity. Medical records are often exchanged prior to a lawsuit or in the early stages of suit. Defendants are most interested in the medical records the plaintiff is not seeking to prove, such as records of pre-existing conditions and accidents, in which instances the defendant seeks to uphold authenticity. A physician's deposition is not absolutely necessary to authenticate or lay a foundation for medical bills and records; everyone knows when, where, how, and why they are created and maintained, and various rules and statutes may be utilized. [105]

VI. Reconciling the Collateral Source Rule, Real Party in Interest Rule & Subrogation

The Collateral Source Rule, and its substantial abrogation through §12-21-45, deals with the policy behind allowing the jury in a personal injury case to know that the person incurring medical bills had insurance to cover those medical bills. [106] A different set of issues arise when the carrier, HMO, or other group obtains a reduction in the stated charge after entering

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[105] Ala. Code 1975, §12-21-5 though §12-21-7. Ala. Code 1975, §12-21-43. *See*, Bodin, *supra*, note 1 (good treatment of the technical aspects of authentication, foundation, and other admissibility requirements).
[106] Ala. Code 1975, §12-21-45, *supra*, note 42.

into agreements and performing reviews. The issue then is not just reimbursement by patient-procured insurance, but also the true amount of the "charge." While it is debatable whether the tortfeasor should benefit from insurance obtained by the injured party, it is less debatable when a significantly lesser amount is actually paid. When the collateral source is not just reimbursing, but also setting charges, it becomes less defensible to keep out evidence of such reimbursement and the manner of its determination. From being an element of proof in a personal injury case, the determination of reasonableness has become a discipline not fully grasped by any one individual. These determinations have swallowed the whole process of medical billing, and in the process become the dominant system over which individual physicians have little say. Older cases debated whether to permit introduction of medical bills before they were proven reasonable or whether to simply instruct the jury whether an unproven bill could be awarded to the plaintiff in the verdict. [107] The modern system determines necessity and reasonableness aspects beforehand in many ways. Often hospital stays must be pre-certified prior to admission, so the medical necessity is determined before the medical services, not later at a doctor's

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[107] *Annotation*, 12 ALR 3d 1347, Necessity and sufficiency, in personal injury or death action, of evidence as to reasonableness of amount charged or paid for accrued medical, nursing, or hospital expenses (1967).

deposition. The "collateral source" now controls the entire process and no longer operates in any collateral manner. Electronic payment is made directly to the provider, in an agreed amount, in the coded languages of reimbursement, under economic circumstances imposed by the source of those funds, and subject to detailed contractual terms.

It has been held that the Collateral Source Rule applies only to amounts paid, not the full stated medical bills. [108] In *Moorhead v. Crozer Chester Medical Center*, it was held that the $96,500.91 difference between the stated bills and the amount paid by Medicare was not paid by a collateral source and that the Collateral Source Rule therefore did not apply. [109] While the Collateral Source Rule says "the wrongdoer cannot take advantage of the contracts or other relation that may exist between the injured person and third persons," [110] and the obtaining of bill reductions by the defendant is doing exactly that, the overriding requirement of payment (or obligation to pay) was never intended to be breached by the original Collateral Source Rule.

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[108] *Moorhead v. Crozer Chester Medical Center*, 763 A.2d 376 (Pa. 2000).
[109] *Id.*
[110] *Marsh v. Green*, 782 So.2d 223, 230 (Ala. 2000).

The rationale for permitting recovery of the full stated bill, even when the carrier paid substantially less, is based upon the reasoning that the wrongdoer should not benefit from insurance purchased by the injured plaintiff. The medical bill scenario can be distinguished with the new factors not present when that rule was established. Medical management was created or given life by Medicare and Medicaid, government programs paid for by all taxpayers, on both the state and federal levels, and by the development of Blue Cross organizations, HMO's, and health insurance. In a manner of speaking, all taxpayers funded the current complex market for medical services, which now largely controls most every aspect of medical billing. Medical management, bill review, fee schedules and the like, coding, regulations, computer programs, and the whole panoply of relevant factors, rule the roost. Fee arrangements and bill reductions came first, before the plaintiff purchased insurance and before the torfeasor caused injury.

The Collateral Source Rule is said to have two basic aspects, one affecting the law of evidence, the procedural side, and the other aspect being substantive, determining the law of damages. [111] The two aspects of the

[111] *See generally, Marsh v. Green*, 782 So.2d 223 (Ala. 2000); The Collateral Source Rule in Alabama: A Practical Approach to Future Application of the

Collateral Source Rule ought to merge in favor of simplicity and the truth. The proposed changes would clarify the law of evidence by facilitating evidence of both the higher stated charges and the lower reimbursement. The plaintiff is already entitled under §12-21-45 to show the cost of procuring their healthcare insurance and the subrogation or re-payment features of their coverage. [112]

The first Alabama pronouncement of the Collateral Source Rule, made before health insurance was common, stated, "The insurance of the property is a mere indemnity, and the insurer and insured are regarded as one person." [113] Originally, the amount of damages was not considered affected by the insurance. [114] The accepted common law pronouncement of the Collateral Source Rule held "that benefits received by the plaintiff from a source wholly independent of and collateral to the wrongdoer will not diminish the damages otherwise recoverable from the wrongdoer." [115] But at the time of these pronouncements, the benefits received were payment of

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Statutes Abrogating the Doctrine, 53 *Ala.L.Rev.* 1249 (2002); Alabama's New Collateral Source Rule: Observations from the Plaintiff's Perspective, 32 *Cumb.L.Rev.* 573 (2001-2002).

[112] Ala. Code 1975, §12-21-45, *supra*, note 42.

[113] *Long v. Kansas City, M.&B.R. Co.*, 170 Ala. 635, 54 So. 62, 64 (1910).

[114] *Id.*

[115] *Marsh v. Green*, 782 So.2d 223, 230 (Ala. 2000).

property damage estimates or stated medical bills, not routine calculation, review, auditing, scheduling, adjustment, and reduction of medical bills.

Six Factors. The original common law Collateral Source Rule only had to deal with two of six factors inherent in the payment of modern medical bills. Those two factors historically were simply the (1) amount of the stated bill or damages and the (2) admissibility or legal effect of the insurance payment. The following four additional and complicating evidentiary factors have been added or magnified since the creation of the Collateral Source Rule: (3) the lower reimbursement rate; (4) the full satisfaction of the higher bills without any balance billing; (5) the insured's duty to repay the carrier out of any award; and (6) the insured's cost of procuring the insurance. Rather than litigating each of these six factors as independent elements of proof, the courts should look at them as a group and facilitate proof of all six once any one of them has been proven or asserted.

The perceived contradiction of allowing two different sets of figures to be seen by the jury is not as awkward as it appears. Juries frequently view contradictory evidence, and in Alabama juries have not been required to accept evidence, including medical bills, the jury finds suspect. Juries are not required to accept all of the numbers, bills, or evidence given to them,

even when they receive only one set of medical charges. In this situation, both sets of figures are actual numbers generated by the providers and the carriers. The public is to some extent aware of these medical charge discounts when health insurance is involved. The Medical Expenses pattern jury charge sets forth the requirement of payment (or obligation to pay) and allows only the amounts paid or to be paid as recoverable damages. [116] The jury might conceivably put a different interpretation on the words "paid" or "become obligated to pay" to reflect payment of the higher stated bill with the lower reimbursement, or to reflect the plaintiff's ultimate duty to pay in the absence of insurance, and award the higher amount. Awarding the higher stated bills could be rationalized as a vestige of the Collateral Source Rule or as another type of damages. As a practical matter, jury awards often exceed the medical expenses by an amount for pain, suffering, economic loss, or disability, which obviates this legal question. The admission of all relevant billing evidence in this context (i.e. both sets of figures) has been termed the Broad Evidence Rule by one legal scholar. [117]

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[116] APJI – 11.09 – Personal Injury – Medical Expenses.
[117] Beard, *supra*, note 4, at 478.

Several Alabama collateral source decisions were rendered as to property damage claims. [118] These decisions are obsolete in light of Fed. R.Civ.P. 17(a) and Ala.R.Civ.P. 17(a), which state that "Every action shall be prosecuted in the name of the real party in interest." [119] In the context the health insurance, the subrogating carrier is the real party in interest to the extent of their payment. Evidence of health insurance, followed by evidence of the plaintiff's duty to repay the carrier out of any recovery, as a practical matter, put the case in the posture of the carrier being a real party in interest to the extent of their payment to the plaintiff, even though the carrier is not a party to the suit. The Real Party in Interest Rule works against the Collateral Source Rule, and that conflict is and ought to be resolved in favor of full disclosure.

The subrogation interest of the carrier or lienor is a matter of law in many instances. Medicare liens, Medicaid liens, hospital liens, and workers' compensation subrogation liens, all operate as a matter of statutory law. [120]

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[118] *Carlisle v. Miller*, 275 Ala. 440, 155 So.2d 689 (1963); *Sturdivant v. Crawford*, 240 Ala. 383, 199 So. 537 (1940); *Long, supra*, note 111.

[119] F.R.Civ.P. 17(a); Ala.R.Civ.P. 17(a). Contrary to these rules, the subrogation interest is often ***not*** prosecuted in the name of the health carrier. Health carriers could be added to many more suits if either party or the courts pressed the matter.

[120] 42 U.S.C. §1395y(b)(2)(B)(ii); Ala. Code 1975, §35-11-370, *et seq.*; Ala. Code 1975, §25-5-11.

Common law, contractual, and equitable subrogation also all operate as a matter of common law or written contract.

The statutory abrogation of the Collateral Source Rule through §12-21-45 applies only to medical and hospital charges, and says nothing about disability insurance or workers' compensation indemnity payments. [121] Section 25-5-11(a) of the Code of Alabama contains its own Collateral Source Rule with regard to third-party actions: ". . . bring an action against the other party to recover damages for the injury or death, and the amount of the damages shall be ascertained and determined without regard to this chapter." [122] Section 12-21-45(a) applies to "all civil actions where damages for any medical or hospital expenses are claimed" [123] and was passed after §25-5-11, [124] thereby restricting but not eliminating the statutory Collateral Source Rule within §25-5-11, which still arguably applies to compensation and vocational disability payments.

VII. Conclusion

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[121] Ala. Code 1975, §12-21-45, *supra*, note 42.
[122] Ala. Code 1975, §25-5-11(a).
[123] Ala. Code 1975, §12-21-45(a), *supra*, note 42.
[124] Ala. Code 1975, §25-5-11.

The amount ultimately paid in full satisfaction of medical charges has always been a mandatory element and the truest test of medical special damages.[125] The reimbursement amount ought to be presumed necessary and reasonable in amount, without the necessity of testimony from the treating physician, subject to the opposing party's right to contradict, impeach, rebut, cross-examine, and otherwise put in dispute the amounts reimbursed. The higher stated bill is increasingly inaccurate as the measure of special damages, especially when viewed in isolation, but serves some vestigial purposes.

The legal system ought to promote transparency, flexibility, cost savings, and simplicity in its rules, pre-trial orders, and substantive law. An increasingly intricate managed care landscape, together with added legal complexity, underscores the need to fight continuously for these goals. To accomplish these objectives, it is necessary to view the medical billing and reimbursement process as a complete and extremely complex system, rather than relying upon increasingly outmoded evidence of the massive system's individual components. Reduction in the number, length, complexity, and cost of medical depositions is attainable in most American courts. [*The End*]

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[125] This applies to satisfied medical bills. The obligation of uninsured plaintiffs to pay the full stated bill is the correct measure of their damages.