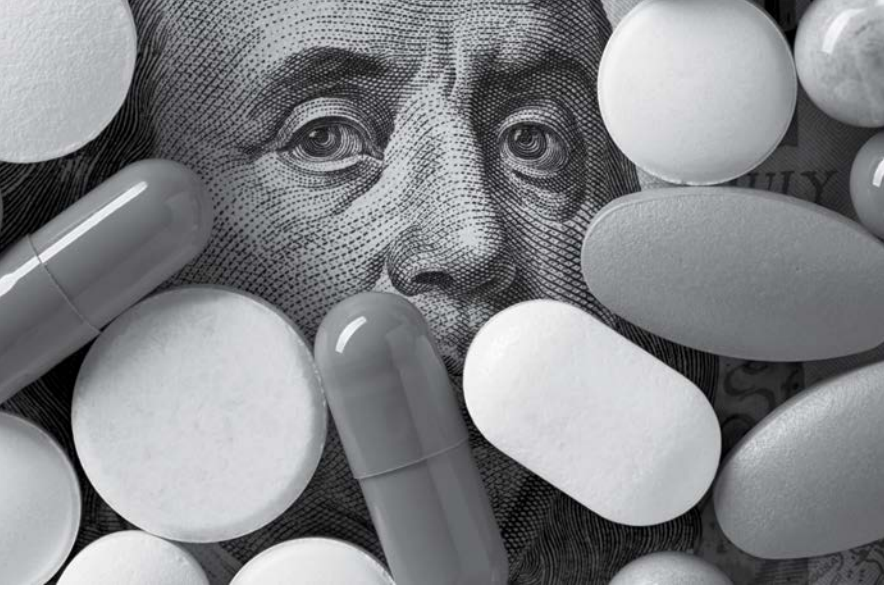

Lien Service Medical Care Is Potentially Actionable Insurance Fraud

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The use of medical lien services for the purpose of inflating medical expense tort damages may be actionable as insurance fraud. Medical services provided on a lien basis may be appropriate in some cases, but California defense counsel are seeing a troubling trend of medical services being provided on a lien basis to tort plaintiffs who have access to medical services through health insurance and/or Medicare eligibility. These medical liens are then asserted by the plaintiffs as the measure of their medical expense damages, even though they often far exceed (often by factors of more than 5 to 10 times) amounts that would have been paid for the same services by the plaintiffs' health insurers had the plaintiffs elected to use the available health insurance, with the expectation that the inflated medical expense damages claims will be paid in full by the defendants' liability insurers.

The obvious aim of inflated medical expense damages claims based on unpaid lien services is to avoid the rule of *Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541, 566 (*Howell*) and its progeny limiting such damages to the *lesser* of the amount actually paid or the *market value* (i.e., the amount *typically paid*) for necessary health care services. Such tactics may be actionable as insurance fraud, since the scheme attempts to improperly inflate the amount of money that defendants' liability insurers must pay.

Reflecting California's strong public policy against insurance fraud, the Insurance Frauds Prevention Act expressly allows insurers to bring qui tam actions to enforce it.

The California Legislature "is vested with the responsibility to declare the public policy of the state." (*Green v. Ralee Engineering Co.* (1998) 19 Cal.4th 66, 71.) It did so when the "Legislature created the Insurance Fraud[s] [Prevention] Act (IFPA) to combat insurance fraud." (*State ex rel. Aetna Health of California, Inc. v. Pain Management Specialist Medical Group* (2020) 58 Cal.App.5th 1064, 1067 (*Pain*); see Ins. Code, § 1871 et seq.) The Legislature declared that "[i]nsurance fraud is a particular problem for automobile policyholders" (Ins. Code, § 1871, subd. (b)) and that the "[p]revention of automobile insurance fraud will significantly reduce the incidence of severity and automobile insurance claim payments and will therefore produce a commensurate reduction in automobile insurance premiums" (*id.*, § 1871, subd. (c)). Indeed, insurance fraud is so contrary to California public policy that it may trigger both criminal and civil penalties under the IFPA. (See Pen. Code, § 550; Ins. Code, § 1871.7, subds. (b) & (c); see also *People ex rel. Allstate Insurance Co. v. Muhyeldin* (2003) 112 Cal.App.4th 604, 606 (*Muhyeldin*) [Insurance Code section 1871.7's civil penalties are "'in addition to any other penalties that may be prescribed by law'"].)

"The Legislature enacted the IFPA to combat insurance fraud committed against insurers by individuals, organizations, and companies." (*Pain, supra*, 58 Cal.App.5th at p. 1069, citing *People ex rel. Allstate Ins. Co. v. Weitzman* (2003) 107 Cal.App.4th 534, 548–549 (*Weitzman*); see *People ex rel. State Farm Mutual Automobile Ins. Co. v. Rubin* (2021) 72 Cal.App.5th 753, 762 (*Rubin*) [the IFPA was amended in 1994 "'"to enact a comprehensive package of laws to assist in the prevention, identification, investigation, and prosecution of insurance fraud"'"]; *People ex rel. Government Employees Ins. Co. v. Cruz* (2016) 244 Cal.App.4th 1184, 1192 (*Cruz*) [the purpose of Insurance Code section 1871.7 "is 'to deter fraudulent automobile insurance claims and to facilitate the investigation and prosecution of insurance fraud'"].) Given its remedial purpose of furthering the public interest in deterring insurance fraud, section 1871.7 is construed broadly. (See *State ex rel. Wilson v. Superior Court* (2014) 227 Cal.App.4th 579, 601–602 (*Wilson*).)

"'Any interested persons, including an insurer, may bring a [qui tam][1] civil action for a violation of [Insurance Code] section [1871.7] for the person and for the State of California.'" (*Muhyeldin, supra*, 112 Cal.App.4th at p. 608, emphasis omitted.) Insurers, in particular, are encouraged to bring qui tam actions to enforce the IFPA. (*Rubin, supra*, 72 Cal.App.5th at p. 762 [the purpose of the IFPA's 1994 amendment "was ' "[t]o help state and local law enforcement agencies *and insurers* to fight insurance fraud" ' "]; *Cruz, supra*, 244 Cal.App.4th at p. 1192 ["Section 1871.7 'has been repeatedly amended specifically to

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authorize *and encourage* insurers to bring fraud actions under the section.'"].) This is because "[i]nsurers are the direct victims of the fraud; insureds are the indirect victims who pay higher premiums due to insurance fraud. [Citation.] 'It is in the government's interest to have insurers investigate and prosecute [qui tam] proceedings. The government serves to gain both in terms of fraud prevention and financially from such actions, especially given limited investigative and prosecutorial resources available to it.'" (*Pain, supra*, 58 Cal. App.5th at p. 1069, citing *Weitzman, supra,* 107 Cal.App.4th at p. 562.)

Attorneys, experts, and litigants may be liable for insurance fraud even though they are not themselves policyholders.

Under the IFPA, "'"*[e]very person*" who engages in insurance fraud ... is subject to penalties and assessments.'" (*Rubin, supra*, 72 Cal.App.5th at p. 762, emphasis added, quoting Ins. Code, § 1871.7, subd. (b).) "[T]he fact that the person making a false claim to an insurance company is not the policyholder, and is not, therefore, in a contractual relation with the insurance company to which the false claim is presented, does not make such person immune from prosecution. Thus, the statute extends to the acts of an attorney in knowingly presenting a fraudulent claim on behalf of a client" in litigation against a defendant who has liability insurance coverage. (39A Cal.Jur.3d (2022) Insurance Contracts, § 641, fns. omitted, citing *People v. Booth* (1996) 48 Cal.App.4th 1247 (*Booth*) [tort plaintiff defrauded defendant's liability insurer by manufacturing false medical and wage loss damages] and *People v. Benson* (1962) 206 Cal.App.2d 519 [plaintiff's attorney and health care provider defrauded defendant's liability insurer by seeking tort recovery based on deceitful medical bills], disapproved on another ground in *People v. Perez* (1965) 62 Cal.2d 769, 776 & fn. 2; accord, *Scofield v. State Bar of Cal.* (1965) 62 Cal.2d 624, 628–629; *People v. Scofield* (1971) 17 Cal. App.3d 1018, 1026 (*Scofield*).)

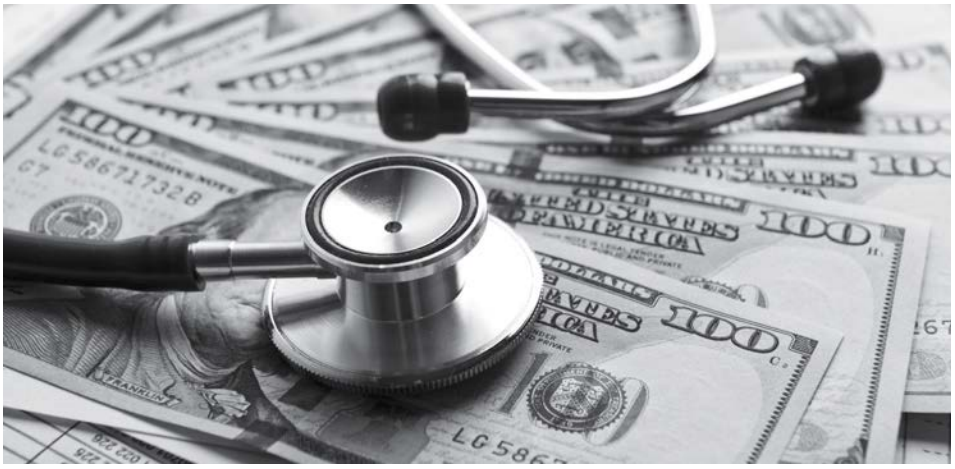
Similarly, a health care provider whose bills are presented in support of a fraudulent medical expense claim tendered by another party can be liable for causing the presentation of the fraudulent insurance claim. (*People v. Singh* (1995) 37 Cal. App.4th 1343, 1369–1370 (*Singh*).) And liability may be imposed on any person or entity that aids and abets with a scheme to present fraudulent or deceitful claims. (Pen. Code, § 550, subd. (a); *People ex rel. Monterey Mushrooms, Inc. v. Thompson* (2006) 136 Cal.App.4th 24, 36–37 (*Thompson*); *Booth, supra*, 48 Cal.App.4th at pp. 1254–1255.) Such liability could potentially extend to expert witnesses who opine on the "reasonableness" of medical bills that vastly exceed the fair market value of the services provided.

Neither the litigation privilege nor collateral estoppel bars a subsequent action for insurance fraud.

In light of the strong public policy favoring actions to deter insurance fraud, neither the litigation privilege nor the workers' compensation exclusive remedy rule may be asserted as a bar to a qui tam action under the IFPA. (*People ex rel. Alzayat v. Hebb* (2017) 18 Cal.App.5th 801, 807–808, 827–831; see *Thompson, supra*, 136 Cal.App.4th at pp. 29–31 [workers' compensation exclusive remedy rule does not preclude insurance fraud action].) Similarly, the anti-SLAPP statute's public interest exception applies to qui tam actions for insurance fraud. (2 Witkin, Summary of Cal. Law (11th ed. 2017) Insurance, § 446, pp. 715–719, citing *People ex rel. Fire Ins. Exchange v. Anapol* (2012) 211 Cal.App.4th 809, 814, 823, 828 and *People ex rel. Strathmann v. Acacia Research Corp.* (2012) 210 Cal.App.4th 487, 502–503.) Moreover, the mere fact that a fraudulent claim was successfully asserted in other litigation (such as a tort action against an insured defendant) does not bar a subsequent action for insurance fraud under principles of res judicata or collateral estoppel. (See *Thompson*, at pp. 31–32.)

Inflating medical expense damages claims may trigger liability for insurance fraud.

Insurance Code section 1871.7, subdivision (b), expressly incorporates Penal Code sections 549, 550, and 551, and authorizes civil penalties (in addition to other penalties) for violation of those statutes. "The elements generally necessary to find a violation of Penal Code section 550 are (1) the defendant's knowing presentation of a false claim, (2) with the intent to defraud." (*Cruz, supra*, 244 Cal.App.4th at p. 1193.) Thus, section 550 liability is created when " 'a false claim for payment of loss is presented to an insurance company or a false writing is prepared or presented with intent to use it in connection with such a claim whether or not anything of value is taken or received.' " (*Ibid.*; see id. at pp. 1193–1194 [" 'It is not necessary that anyone actually be defrauded or actually suffer a financial, legal, or property loss as a result of the defendant's acts' "], 1199 [section 550 "does not require that a fraudulent claimant's scheme be successful to establish her liability; she need only knowingly present a false claim with the intent to defraud"].) Intent to defraud "may



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be determined by consideration of all the circumstances in evidence." (*Singh, supra*, 37 Cal.App.4th at p. 1371.)

Penal Code section 550, subdivision (b)(1) makes it "unlawful to '[p]resent or *cause to be presented any written or oral statement as part of, or in support of … a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact' or to 'knowingly assist or conspire with any person' to do so." (Martinovsky v. County of Alameda* (2017) 82 Cal.Comp. Cases 227, 238 (*Martinovsky*), emphasis added.) "For assessment of penalties under [Insurance Code section] 1871.7, the alleged misconduct need only be 'in some manner deceitful' and insurance claims need not necessarily contain express misstatements; causation may be established under the standard substantial-factor test, and application of a 'but-for' test is not required." (2 Witkin, Summary of Cal. Law, *supra,* Insurance, § 446, p. 716; accord, *Wilson, supra,* 227 Cal.App.4th at pp. 586, 592, 594 [the " 'fraudulent claim' requirement refers broadly to claims that are in some manner deceitful, and is not limited to claims that contain an express misstatement of fact"], 601 [insurance fraud "must be interpreted broadly, to encompass not just claims that can be shown to themselves contain fraudulent statements, but also those characterized in any way by deceit" including any "dishonesty, or trickery perpetrated to gain some unfair or dishonest advantages"], 602 [same], 604, 607–609.)

Making a direct claim for payment from an insurer based on fraudulent and/or inflated bills is plainly actionable as insurance fraud. For example, evidence that treating physicians "intentionally and knowingly us[ed] improper billing codes – Current Procedural Technology (CPT) Codes – to inflate their bills" and "knowingly billed for services that were never performed" led to an insurance judgment in excess of $7 million that was affirmed on appeal. (*Muhyeldin, supra,* 112 Cal.App.4th at pp. 606–608, 612; see *Cruz, supra,* 244 Cal.App.4th at pp. 1186–1187, 1198–1199 [reversing summary judgment for defendant physician because triable issues of material fact existed regarding physician's upcoding and billing for services never rendered which could support qui tam action for violation of Penal Code section 550]; *Thompson, supra,* 136 Cal.App.4th at pp. 27–28, 39;"]; *Scofield, supra,* 17 Cal.App.3d at pp. 1022–1026; *Martinovsky, supra,* 82 Cal.Comp.Cases at p. 230 [physicians criminally prosecuted for insurance fraud based on billing for services that were not provided and presenting payment claims that "'contained false and misleading information'" regarding a material fact]; *Singh, supra,* 37 Cal.App.4th at pp. 1356–1357, 1360–1362, 1371 [health care provider's insurance fraud liability was based on "overtreat[ing] his patients by using medically unnecessary diagnostic

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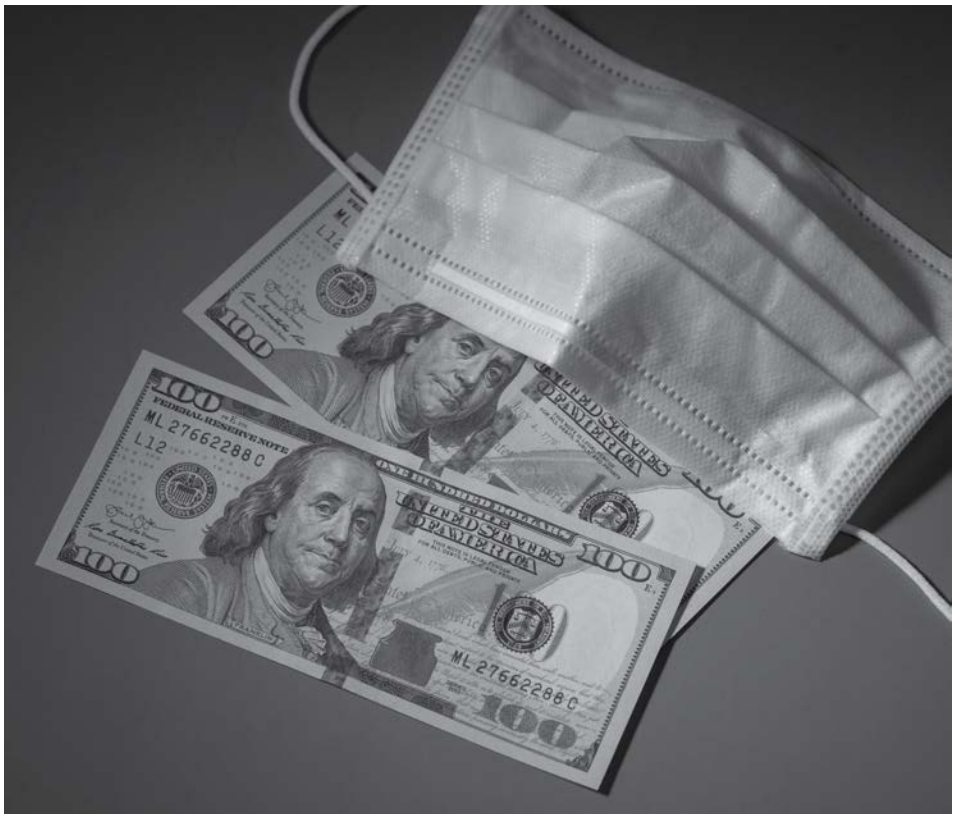
tests ... and pain therapies" and for overcharging for the pain therapy], 1374 [rejecting provider's argument that "he was free to charge whatever he wanted in personal injury cases; see also *Rubin, supra,* 72 Cal.App.5th at pp. 764–767 [reversing a dismissal under the first to file rule in connection with an alleged insurance fraud scheme involving inflated medical bills and misused CPT codes]; *United States v. United Healthcare Insurance Company* (9th Cir. 2016) 848 F.3d 1161, 1175 [improper diagnosis codes submitted by Medicare Advantage organizations support federal False Claims Act (FCA) claim].)

Evidence of fraudulent health service billing has come from expert witnesses, patients, and former employees of the health care provider who have testified regarding such fraudulent activity as upcoding bills to recoup greater payments than warranted, billing for services that were not provided, and the routine practice of providing services to subsets of patients with insurance coverage that are not provided to patients paying cash. (See, e.g., *Cruz, supra,* 244 Cal.App.4th at pp. 1198–1199; *Muhyeldin, supra,* 112 Cal.App.4th at p. 607; *Singh, supra,* 37 Cal.App.4th at pp. 1360–1362, 1371–1372; *Scofield, supra,* 17 Cal.App.3d at pp. 1023–1024.)

In contexts other than medical services, claims seeking insurance proceeds that greatly exceed the fair market value of a loss have supported liability for insurance fraud. (See *People v. Kanan* (1962) 208 Cal. App.2d 635, 636–637, 638 ["If the valuation set forth in the claim filed by the defendant is so grossly disproportionate to what is shown to have been the actual value of the property destroyed ... then clearly there was a showing of an intent to defraud"]; see also *People v. De Caro* (1981) 123 Cal.App.3d 454, 457–458, 459 [evidence supporting insurance fraud conviction included evidence the claimant "had listed a number of [allegedly lost] items at *greatly inflated (25%)* prices" (emphasis added)].)

Under Penal Code section 550, subdivision (b)(1), seeking to recover medical expense damages in a tort action that greatly exceed the fair market value for such services may



be actionable as insurance fraud where the defendant is covered by liability insurance. This is because such conduct arguably will "cause to be presented any written or oral statement as part of, or in support of ... a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact" and/or "knowingly assist or conspire with any person" to do so. (*Ibid.*)

A tort plaintiff's medical expense damages must be measured by the fair market value of the needed services and not by highly inflated unpaid medical bills. (*Howell, supra,* 52 Cal.4th at pp. 555, 561–562, 567; *Cuevas v. Contra Costa County* (2017) 11 Cal.App.5th 163, 179; *Markow v. Rosner* (2016) 3 Cal.App.5th 1027, 1050–1051; *Ochoa v. Dorado* (2014) 228 Cal. App.4th 120, 135–139; *State Farm Mutual Automobile Ins. Co. v. Huff* (2013) 216 Cal. App.4th 1463, 1471–1473; *Corenbaum v. Lampkin* (2013) 215 Cal.App.4th 1308, 1330–1331, 1333.) The Restatement Second of Torts, "[s]ection 911 articulates a rule, applicable to recovery of tort damages generally, that the value of property or services is ordinarily its 'exchange value,' that is, its market value or the amount for which it could usually be exchanged." (*Howell,* at p. 556; accord, *Bermudez v. Ciolek* (2015) 237 Cal.App.4th 1311, 1329 ["*Howell* endorsed 'a rule, applicable to recovery of tort damages generally, that the value of property or services is ordinarily its "exchange value," that is, its market value or the amount for which it could usually be exchanged'"]; *Hefczyc v. Rady Children's Hospital-San Diego* (2017) 17 Cal.App.5th 518, 542 ["The scope of the *rates accepted by or paid to* Hospital by other payors indicates the value of the services in the marketplace" (emphasis added)], disapproved on another ground in *Noel v. Thrifty Payless, Inc.* (2019) 7 Cal.5th 955, 986, fn. 15; *Children's Hospital Central California v. Blue Cross of California* (2014) 226 Cal.App.4th 1260, 1275 ["reasonable market value of the services at issue, i.e., the price that would be agreed upon by a willing buyer and a willing seller negotiating at arm's length"], superseded by statute on another ground as stated in *Dignity Health v. Local Initiative Health Care Authority of Los Angeles County* (2020) 44 Cal.App.5th 144, 160.)

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FCA decisions are persuasive authority regarding the scope of the IFPA. (*Rubin, supra,* 72 Cal.App.5th at pp. 769–770 [because the IFPA "was modeled after the California False Claims Act [citation], which was '[p]atterned after the federal False Claims Act'" and because "the IFPA and FCA share a similar design and purpose," it is appropriate to consider authority construing the FCA when construing the IFPA].) Federal courts uniformly recognized the validity of FCA claims against drug manufacturers and pharmacies that use schemes to report inflated "usual and customary" (or "average wholesale") prices in order to increase reimbursements for the sale of prescription drugs to Medicare beneficiaries – usually by ignoring the low cash price available for the drugs. (See *United States ex rel. Garbe v. Kmart Corporation* (7th Cir. 2016) 824 F.3d 632, 635–644; *United States ex rel. Shemesh v. CA, Inc.* (D.D.C 2015) 89 F.Supp.3d 67, 69–80; *United States ex rel. Streck v. Takeda Pharmaceuticals America, Inc.* (N.D.Ill. 2019) 381 F.Supp.3d 932, 934–940; *United States v. Supervalu, Inc.* (C.D.Ill. 2016) 218 F.Supp.3d 767, 770–775; *United States ex rel. Garbe v. Kmart Corporation* (S.D.Ill. 2013) 968 F.Supp.2d 978, 981–990; *U.S. ex rel. Ven-A-Care v. Actavis Mid Atlantic LLC* (D.Mass. 2009) 659 F.Supp.2d 262, 264–271.) This federal authority holding that the FCA is violated by using inflated "usual and customary" prices to obtain excessive Medicare reimbursements supports the analogous claim that the IFPA is violated by using inflated usual and customary medical expenses to recover damages that an insurer is obligated to pay.

Where tort plaintiffs and their counsel are on notice that the defendant has liability insurance, they may be liable for insurance fraud under the above authority for inflating medical expense damages claims by presenting evidence regarding unpaid medical bills from lien providers that greatly exceed the fair market value for the health care services provided to the plaintiffs. The plaintiffs' treating health care providers, life care planners, and other experts used to support the recovery of excessive medical expense damages awards could be liable as well for aiding and abetting the commission of insurance fraud. Imposing such liability would be consistent with the authority cited above, and would further California's strong public policy against insurance fraud.

Using runners and cappers also triggers insurance fraud liability.

It is unlawful "to knowingly employ runners, cappers, steerers, or other persons ... to procure clients or patients to perform or obtain services or benefits under a contract of insurance or that will be the basis for a claim against an insured individual or his or her insurer." (Ins. Code, § 1871.7, subd. (a).) "Subdivision (a) is

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violated by the employment of others with that objective; it does not make proof of that result a prerequisite to its violation." (*Wilson, supra,* 227 Cal.App.4th at p. 593 ["there can be a violation of subdivision (a) without proof that the item or service of value provided or promised to the physician caused a particular" item or service to be provided]; see *id.* at p. 594 ["Certain conduct is defined as unlawful by Insurance Code section 1871.7, subdivision (a) and by Penal Code section 550, without regard to any result the conduct may or may not cause"].) Moreover, "there can be a violation of subdivision (a) even if the claim contains no express misstatement of fact and does not disclose the unlawful conduct." (*Id.* at p. 594.)

Evidence of a financial relationship between a health care provider and an attorney referring patients to the provider for treatment on a lien basis could support liability under Insurance Code section 1871.7, subdivision (a). For example, liability could be based on evidence the attorney purchased an inflated medical lien, either directly or through a "factor" owned or controlled by the attorney, at a fraction of the lien amount, thereby allowing the provider and the attorney to share the excessive proceeds recovered from a liability insurer by operating a scheme to inflate medical expense damages. (Cf. *Cruz, supra,* 244 Cal.App.4th at p. 1198 [liability for unlawful referral agreement may be supported by evidence the physician pays "rent" to referring physician in excess of "fair market value" of the rented space].) The imposition of such liability would likewise further California's strong public policy against insurance fraud.

Inflating medical expense damages claims also may trigger liability under the Unfair Competition Law.

The purpose of the Unfair Competition Law (UCL) (Bus. & Prof. Code, § 17200 et seq.) is to prohibit " 'unfair, dishonest, deceptive, destructive, fraudulent and discriminatory practices by which fair and honest competition is destroyed or prevented.'" (*Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone Co.* (1999) 20 Cal.4th 163, 179 (*Cel-Tech*).) The UCL "focuses solely on conduct and prohibits ' "anything that can properly be called a business practice and that at the same time is forbidden by law."' [Citations.] 'As a result, to state a claim under the [UCL] one need not plead and prove the elements of a tort. Instead, one need only show that "members of the public are likely to be deceived."'" (*Charles J. Vacanti, M.D., Inc. v. State Comp. Ins. Fund* (2001) 24 Cal.4th 800, 827.)

"Under the UC[L], unfair competition means and includes 'any unlawful, unfair or fraudulent business act or practice.' The act authorizes courts to enjoin such conduct and order restitution of money or property obtained by means of unfair competition. Actions for relief under the UC[L] can be prosecuted 'by any person acting for the interests of itself, its members or the general public.'" (*Klein v. Earth Elements, Inc.* (1997) 59 Cal.App.4th 965, 968–969, emphasis and citations omitted.) "An unlawful business practice or act is an act or practice, committed pursuant to business activity, that is at the same time forbidden by law." (*Id.* at p. 969, citing *Farmers Ins. Exchange v. Superior Court* (1992) 2 Cal.4th 377, 383.) "Virtually any law can serve as the predicate for a [Business and Professions Code] section 17200 action." (*Ibid.*) "By proscribing 'any unlawful' business practice, 'section 17200 "borrows" violations of other laws and treats them as unlawful practices' that the unfair competition law makes independently actionable." (*Cel-Tech, supra,* 20 Cal.4th at p. 180.)

Thus, counsel for plaintiffs, lien providers, and expert witnesses who have a business practice of inflating medical expense damage claims in violation of the IFPA (Ins. Code, § 1871.7; Pen. Code, § 550) may be enjoined from continuing that practice and ordered to disgorge money obtained through the unfair or unlawful business practices under the UCL (see *Korea Supply Co. v. Lockheed Martin Corp.* (2003) 29 Cal.4th 1134, 1144). V

Endnotes:

1 "The phrase 'qui tam' is taken from the longer Latin expression 'qui tam pro domino rege quam pro se ipso in hac parte sequitur,' meaning 'who brings the action for the king as well as for himself.' " (U.S. ex rel. Davis v. Prince (2011) 753 F.Supp.2d 569, 573, fn. 1, citing 3 Blackstone's Commentaries 160.) (If you've read this far, you probably wanted to know that.)

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