

A Practical Approach for Practitioners and Claims Professionals

By Bradford G. Hughes
and Charles Wendland

Attorney-directed medical treatment has become more prevalent over the past several years, resulting in fraudulent billing, excessive treatment, and dangerously invasive procedures.

Attacking Lawyer-Driven Treatment

Personal injury plaintiffs routinely seek medical care at the direction of their attorneys. A plaintiff attorney often will refer several clients to the same healthcare providers, based on the nature of the injury claimed by the plaintiff,

counsel's prior experience with the healthcare provider, previous trial results with the healthcare provider, and the flexibility of the healthcare provider in negotiating post-settlement lien reductions.

A spate of recent lawsuits brought by various state attorneys general and insurance companies have revealed both elaborate, and not-so-elaborate, bribery and fraud schemes perpetuated by healthcare providers and plaintiff attorneys to over-treat and overbill for medical services. Trucking defense practitioners in virtually every jurisdiction have also identified a significant uptick in the number of personal injury plaintiffs that are undergoing aggressive and expensive healthcare treatments at the direction of their counsel. In some situations, plaintiffs are undergoing surgical procedures in the pre-litigation stages of a case that would have been unthinkable less than a decade ago.

This article is intended to provide the defense practitioner and the claim professional with practical tools for dealing with, rebutting, and hopefully stopping runaway medical treatment that is directed by a plaintiff counsel that is unnecessary and extreme.

The Problem

Fraud in medical billing is certainly not a new development in the United States. Nor is it news to any experienced defense practitioner that a relationship between the plaintiffs' bar and a network of cooperative healthcare providers exists. However, many states and large insurance carriers have taken the fight back to these bad actors, which has resulted in the unveiling of hundreds of millions of dollars in fraud in the medical-legal industry.

In November 2015, the FBI announced that five individuals, including two doc-



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tors, were being charged in kickback schemes involving nearly \$600 million in fraudulent claims by Southern California hospitals. The former chief financial officer of a Long Beach, California, hospital, two orthopedic surgeons, and two others were charged in long-running healthcare fraud schemes that illegally referred thousands of patients for spinal surgeries and generated nearly \$600 million in fraudulent billings over an eight-year period.

The schemes involved tens of millions of dollars in illegal kickbacks to dozens of doctors, chiropractors, and others. As a result of the illegal payments, thousands of patients were referred to Pacific Hospital in Long Beach, where they underwent spinal surgeries that led to more than \$580 million in fraudulently submitted bills during the last eight years of the scheme alone. Many of the fraudulent claims were paid by the California worker's compensation system and the federal government. Press Release, FBI, Five Individuals, Including Two Doctors, Charged in Kickback Schemes Involving Nearly \$600 Million (Nov. 24, 2015), <https://www.fbi.gov>.

In New Jersey, five doctors were charged in a statewide health-care-related bribery conspiracy involving doctors, lawyers, and medical facility operators. Tom Davis, *NJ Doctors Busted in Statewide Bribery Kickback Scheme*, Wayne, New Jersey, Patch (June 13, 2017), Patch.com. A Passaic County chiropractor was charged with illegally accepting tens of thousands of dollars from a medical imaging center for referring patients to the center. Similar to the case in Southern California, the doctors would receive monetary kickbacks from referring attorneys or other physicians and provide treatment or examinations that were unnecessary and unreasonable.

In October 2017, investigators broke up a massive auto insurance fraud operation in Florida. The FBI alleged that two men "ran a highly profitable crime ring of corrupt clinic owners, chiropractors, and lawyers," which operated mostly in three counties. Paula McMahon, *Massive \$23 Million Auto Insurance Fraud Was an Intricate Operation*, Sun Sentinel (Oct. 14, 2017), <http://www.sun-sentinel.com>.

Prosecutors said that "it was an elaborate operation that—by conservative estimates—defrauded more than \$23 mil-

lion from 10 auto insurance companies" between 2010 and sometime in 2017. *Id.* The fraudsters paid kickbacks of \$500 to \$2,100—per patient—to tow truck drivers and body shop workers who agreed to accident victims to chiropractic clinics, which the defendants owned. *Id.*

Prosecutors alleged that the defendants recruited tow truck drivers, body shop workers, and others who had access to traffic crash reports. They referred drivers or passengers who were involved in a crash to the chiropractor clinics. The referring "runners" were paid the illegal kickbacks, mentioned above. One "runner" referred about 750 "patients" to the clinics, and he received up to \$2,000 for each referral, which, in his estimation, amounted to "more than \$1 million, much of it in cash, over several years." *Id.* Some attorneys also paid kickbacks to the clinics for the clinics to refer patients to the attorneys so that they could file bodily injury lawsuits for the patients.

The fraud allegedly required the patients to get a lot of treatments and expensive tests to amass huge bills in a short time span and took advantage of no-fault provisions in Florida's Personal Injury Protection insurance (PIP). In addition, many patients "were ordered to undergo unnecessary and painful nerve tests that cost about \$1,000 each, and others were sent for unnecessary MRIs." *Id.*

In November 2012, a Los Angeles Superior Court judge ordered Daniel H. Dahan, D.C., and his business, Progressive Diagnostic Imaging, to pay Allstate Insurance Company \$7,010,668.40 in a qui tam (whistleblower) lawsuit, arising out of insurance fraud, that included \$4,870,000 in civil penalties, \$918,516.78 in assessments, and \$1,222,151.62 in attorney's fees, costs, and investigative expenses. Stephen Barrett, M.D., *Allstate Wins \$7 Million Judgment in Another Chiropractic Fraud Case*, Chirobase (Dec. 14, 2012), <https://www.chirobase.org>. Dahan was "also prohibited from owning, operating, or working as an employee in any business engaged in the practice of medicine." *Id.*

As explained elsewhere, "Allstate's lawsuit alleged that Dahan purchased report-writing software that purported to analyze x-rays and form medical opinions and diagnoses, including opinions concerning

permanent impairment ratings, and thereafter formed Progressive Diagnostic Imaging to solicit x-rays from chiropractors, with the assurance that 'board certified radiologists' would analyze the films." *Id.*

In January 2017, a Chicago-area chiropractor and two family members who worked at his clinic admitted to running a six-year, \$29 million scheme to defraud Blue

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Cross Blue Shield and several other health insurers. The three individuals pleaded guilty to using the clinic to submit about \$28.78 million in false health insurance claims. Patients, clinic staff, and the owner of an ultrasound company helped them. Two other chiropractors in the practice were ordered to create fake medical records for the patients to support the claims, using software designed by one of the three fraudsters. The other chiropractors weren't charged in the scheme. Diana Novak Jones, *Chiropractor, Family Admit to \$29M Health Care Fraud*, Law360 (Jan. 6, 2017).

Pre-Suit Investigation

Combatting attorney-driven, healthcare treatment starts immediately after an accident occurs. Exceptional claims professionals know that proactive and thorough claims management can expedite an early resolution to a claim and keep a case from getting out of hand. When early claims

management is unfeasible, or the claimant is uncooperative, defense practitioners have some best practices to combat problematic attorney-driven treatment with success.

Know Your Plaintiff Attorney

With few exceptions, most personal injury plaintiff attorneys are known by other

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defense lawyers in their respective jurisdictions. Indeed, counsel may have had cases together previously, interacted at a local bar event, or know one another from prior interactions. Asking your local defense counsel about the plaintiff attorney who has provided a letter of representation is the critical first step to understanding what the future of the case truly holds. Plaintiff attorneys that drive their clients to specific healthcare professionals, or who encourage their clients to undergo aggressive and unnecessary medical procedures, are normally well known throughout the local defense bar. If you know that the opposing attorney will engage in the kinds of behaviors outlined above, you are ahead of the game and able to set up a more effective defense.

Know Your Treating Physicians

The medical-legal healthcare provider community in most jurisdictions is smaller than some defense practitioners initially expect. Save for the largest metropolitan

areas, there are usually only a handful of healthcare professionals that are willing to take on attorney-referred patients on a lien basis and then provide expensive medical treatment (sometimes without any guarantee of getting paid). Even in major metropolitan areas, most defense practitioners are aware of the “problem” healthcare providers. Defense practitioners and claims professionals should seek the proverbial scouting report on any treating physician.

Some readily available resources to help with this follow:

- Online defense attorney community forums
- Online expert databases
- County defense bar association community messaging boards
- Defense-oriented healthcare providers in the jurisdiction

Pre-Suit Surveillance

When done correctly, there is often no substitute for pre-suit surveillance that shows a personal injury plaintiff engaged in conduct that he or she eventually testifies is a physical impossibility. If you are aware that a plaintiff is receiving treatment from a specific healthcare provider, or seeking treatment for a specific type of injury (e.g., low back pain), then it is prudent to weigh the costs and benefits of getting surveillance on the plaintiff. For example, if you know that a plaintiff is seeking treatment with an orthopedic surgeon for low back pain, but you can get evidence of the plaintiff playing golf at the same time that the orthopedic surgeon was allegedly rendering treatments, that claim quickly loses validity.

Pre-suit surveillance is not without its risks, however. In some jurisdictions, surveillance of a plaintiff must be disclosed to the plaintiff during the discovery process. When confronted with surveillance of a plaintiff, savvy healthcare providers can sometimes flip the script and use that as evidence that the treatment was effective in helping a plaintiff relieve ongoing symptoms. Other healthcare providers will brush off damning surveillance as being attributable to a natural ebb and flow of symptomology.

The author would suggest that surveillance should always be considered on a case-by-case basis. Surveillance done

wrong can have a catastrophic effect on the defense case if presented to a jury. And surveillance that only serves to promote a claimed injury has similar negative consequences for the defense case.

Pre-Suit Request for an Independent Medical Examination

Many independent medical examinations (IMEs) are rendered ostensibly useless because the defense doctor never had an opportunity to examine a plaintiff before invasive treatment was provided. For example, unless the defense healthcare provider had an opportunity to examine the plaintiff before he or she underwent a low-back discectomy, the defense healthcare provider’s opinion that the surgery was not needed will be based largely on only what the doctor can glean from pre-operative records. This creates a less than ideal scenario before a jury for the defense trial lawyer.

If, depending on the plaintiff attorney or the treating physician involved, you have reason to suspect that a surgical intervention is likely, it is prudent to request that the plaintiff submit to a pre-suit IME. While there would be no way to compel a plaintiff to undergo a pre-suit IME, the following steps can be taken to preserve the argument of prejudice to the defense at the time of trial.

First, send the plaintiff’s counsel a request for a pre-suit IME. Offer to have the examination at as soon as possible to diffuse the counterargument that defense counsel is trying to prevent the plaintiff from seeking healthcare treatment on the timeline set by the plaintiff.

Second, send the plaintiff’s counsel a letter explaining the prejudice to the defense. Laying out the practical and real prejudice to the defense in a letter to the plaintiff’s counsel will help to preserve the issue after suit is filed.

Third, send the plaintiff’s counsel a preservation of evidence letter. Preservation letters are common in pre-suit communications between the parties. If the defense practitioner determines that the plaintiff will likely undergo invasive treatment before an independent medical examination can be completed, a preservation letter can be sent to the plaintiff’s counsel to allow the defense to examine the “evi-

dence” before it is altered. While this practice has not been thoroughly examined by any significant courts to date, it again serves to preserve the defense position, and ideally, it will assist in getting a pre-suit IME completed.

Some courts are becoming less reluctant to issue an adverse jury instruction if there is evidence that a plaintiff engaged in intentional and bad-faith conduct with respect to disclosing treatment. In *Laganeaux v. Lowes Home Centers, Inc.*, Case 6:08-cv-01744-CMH [Doc. 45] (W.D. La.), the court agreed to issue an adverse inference jury instruction based on spoliation of evidence as a sanction for the plaintiff’s intentional and bad-faith conduct in failing to notify defense counsel of the plaintiff’s decision to undergo surgery before having the surgical procedure, and for the plaintiff’s failure to provide a timely supplemental response to defense interrogatories. In that case, the defendant asked to be notified by the plaintiff at least 60 days before undergoing any surgical intervention so that a pre-surgery IME could be completed, and the plaintiff agreed to the request. However, apparently without the knowledge of the plaintiff’s counsel, the plaintiff underwent a back surgery during the course of the case and without giving the defense counsel the agreed-upon notice. As a result, the court found that an adverse jury instruction was appropriate as a sanction for spoliation of evidence.

After the Complaint Is Filed

After a complaint is filed, defense counsel has several strategies to draw from to deal with situations in which a plaintiff’s attorney becomes involved in directing the plaintiff to have inappropriate treatment.

Subpoenas to Treating Healthcare Providers

A plaintiff’s medical records should always be obtained from treating physicians—either through a HIPAA (Health Insurance Portability and Accountability Act) compliant release or through subpoena. Subpoenas should also be issued seeking documentation that can establish that a plaintiff is being given disparate treatment from other similarly situated patients and that the healthcare provider has a cozy (biased) relationship with the plain-

tiff attorney. Subpoenas should be issued to treating physicians seeking the following:

- all prior cases in which the plaintiff’s counsel has referred patients to the healthcare provider;
- any existing agreements for the healthcare provider to be paid sums less than those billed for the plaintiff’s counsel; and
- treatment of other similarly situated patients, including prognosis and the care given.

It is imperative that the defense practitioner draft these subpoenas with an eye toward the likely objections that would be raised by the opposing side or the healthcare provider. To this end, the subpoena should request that all patient identifiable information be redacted.

Thoughtfully Using Interrogatories

Not all attorney-driven treatment occurs before a lawsuit is filed. Indeed, in many circumstances, treatment is ramped up before mediation or trial, which results in surprises that are not helpful to the defense. An oft-overlooked option for defense attorneys is to ask a plaintiff in written discovery to agree that he or she will not undergo a treatment or procedure until notifying defense counsel in advance so that the defendant may obtain an IME before the anticipated procedure. Given that Rule 37(c) of the Federal Rules of Civil Procedure provides for sanctions against a party that fails to comply with the duty to supplement a discovery response, interrogatories can cast an ongoing obligation to keep defense counsel apprised of treatment.

As with pre-suit requests for an IME, post-suit interrogatories need to be carefully drafted so that the defendant does not impede treatment and therefore take out of controversy the issue of whether the plaintiff has failed to mitigate his or her damages. Keep in mind that a plaintiff’s obligation to mitigate damages is an effective and useful tool at trial, so avoid drafting communications or interrogatories that can be used against your client and make it look as if a plaintiff could not mitigate his or her damages because the defense wanted to control treatment. The goal is to prevent improper treatment that is guided by those who are not healthcare professionals, not to prevent a plain-

tiff from receiving timely and necessary medical treatment.

Dealing with Privilege

Predictably, plaintiff attorneys routinely use the protections afforded by the attorney–client privilege to protect the discovery of their involvement in directing medical treatment of clients. However, it is well

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settled that while communications can be privileged, facts are not. Additionally, “[a] party asserting the attorney–client privilege has the burden of establishing the [existence of an attorney–client] relationship and the privileged nature of the communication.” *United States v. Ruehle*, 583 F.3d 600, 607 (9th Cir.2009) (quoting *United States v. Bauer*, 132 F.3d 504, 507 (9th Cir.1997)). And “[b]ecause it impedes full and free discovery of the truth, the attorney–client privilege is strictly construed.” *Id.* (quoting *United States v. Martin*, 278 F.3d 988, 999 (9th Cir.2002)). An eight-part test determines whether information is covered by the attorney–client privilege:

- (1) Where legal advice of any kind is sought
- (2) from a professional legal adviser in his capacity as such,
- (3) the communications relating to that purpose,
- (4) made in confidence
- (5) by the client,
- (6) are at his instance permanently protected
- (7) from disclosure by himself or by the legal adviser,
- (8) unless the protection be waived.

Id. (quoting *In re Grand Jury Investigation*, 974 F.2d 1068, 1071 n. 2 (9th Cir.1992)). As for meeting the test, “[t]he party asserting the privilege bears the burden of proving each essential element.” *Id.* at 608 (citing *United States v. Munoz*, 233 F.3d 1117, 1128 (9th Cir.2000), superseded on other grounds as stated in *United States v. Van Alstyne*, 584 F.3d 803, 817 (9th Cir.2009)).

Counsel should ask a plaintiff how he or she came to find different healthcare providers and the methodology that he or she used to seek those referrals.

The eight-part test described above can be used to overcome any purported attorney–client privilege objection raised by plaintiff’s counsel. As an initial matter, it would be difficult to establish that determining that a plaintiff should have medical care of a specific nature would be deemed “legal advice” to that plaintiff or that the advice was sought from the lawyer in his or her capacity as a lawyer. See *United States v. Graf*, 610 F.3d 1148 (2010).

Magistrate judges have held that the existence of a fee arrangement between a plaintiff’s counsel and the plaintiff’s treating physician is not privileged.

The mere fact that requested information relates to an attorney–client relationship does not entitle it to protection under the attorney–client privilege. The Ninth Circuit, for example, has long held that attorney fee arrangements usually fall outside the scope of the attorney–client privilege ‘simply because such information ordinarily reveals no confidential professional communication between attorney and client, and not because such information may not be incriminating.’ *In Re Osterhoudt*, 722 F.2d 591, 593 (9th Cir.1983). See also *Ralls v. United States*, 52 F.3d 223, 225–26 (9th Cir.1995). The courts also hold that fee

agreements are not protected from disclosure under the attorney work-product doctrine which is designed to prevent ‘unwarranted inquiries into the files and mental impressions of an attorney.’ *Murray v. Stuckey’s Inc.*, 153 F.R.D. 151, 153 (N.D. Iowa 1993); *Montgomery County v. Micro Vote Corp.*, 175 F.3d 296, 304 (3rd Cir.1999); *Henry v. Rizzolo*, 2009 WL 1886272, at *2 (D. Nev. 2009).

Allstate Insurance Co. v. Nassiri, D.C., et al., 2011 WL 810088 (D. Nev. 2011). See also *Soriano v. Treasure Chest Casino, Inc.*, Case No. 95-3945, 1996 WL 736962, at *2 (E.D. La. Dec. 23, 1996) [“To the extent the discussions regarding referrals to doctors and other experts dealt with this litigation, such as referrals for expert opinion to be utilized for this matter, the discussions are protected. To the extent the discussions did not facilitate legal issues, such as referrals simply for the health of the plaintiff, the discussions are not protected.”].

Deposing a Plaintiff

Depositions are one of the best tools to establish attorney-driven and inappropriate medical care. Unlike written discovery, for which a lawyer drafts responses on behalf of the client (rendering the responses limited in value), a deposition allows a plaintiff the chance to speak without the filter of his or her counsel. For lack of a more artful description, defense counsel should directly ask a plaintiff who sent him or her to each healthcare provider. Alternatively, counsel should ask a plaintiff how he or she came to find different healthcare providers and the methodology that he or she used to seek those referrals. The net result of thorough questioning will establish that even if a plaintiff does not testify that his or her attorney sent the plaintiff for each stage of treatment, that plaintiff was not referred by the prior physician.

Time during the deposition should also be devoted to eliciting the subjective testimony of a plaintiff about he or she felt before undergoing the invasive surgical procedure proscribed by his or her counsel. Under the right circumstances, a plaintiff will testify that he or she did not suffer from one of the key indicators of the injury for which the surgical procedure was intended. Defense counsel must be exceptionally knowledgeable about human

anatomy, symptomology, and indicators of specific injury before taking a plaintiff deposition. Further, counsel should be encouraged to meet and confer with the defense experts before the deposition of a plaintiff to establish what testimony should be elicited for the expert ultimately to testify that the treatment received by the plaintiff was not reasonable or medically necessary.

Deposing the Treating Healthcare Provider

Of obvious critical importance is the thorough and thoughtful cross-examination of the treating physician. Healthcare providers in the medical-legal field are routinely and repeatedly deposed on a consistent basis, so they should be approached with the same care and expertise as a plaintiff’s retained experts.

A good place to start with treating physicians is the Hippocratic Oath taken by doctors to “first, do no harm.” From there, counsel should cross-examine a treating healthcare provider regarding his or her treatment of a plaintiff, the medical support for the treatment provided, and a comparison of whether the treating physician has ever provided such care to similarly situated patients. Examination should also be devoted to the time, or lack of it, that the treating healthcare provider dedicated to conservative courses of treatment.

For example, a herniated disc can sometimes heal itself through a conservative course of treatment because the body is equipped to reabsorb the herniated disc material and then use that to heal the damaged disc. If, however, a plaintiff underwent a surgical intervention less than two months after suffering an alleged herniated disc, there would be a possible argument that the treating healthcare provider rendered unnecessary, unreasonable, and medically unwarranted treatment.

A treating healthcare provider should be cross-examined regarding his or her relationship with a plaintiff’s counsel. As discussed above, a treating healthcare provider should be approached as you would a retained expert witness and examined for inherent biases. How many patients has the doctor been referred by a plaintiff’s attorney? How long has their referral relationship existed? Does the doctor refer patients to the attorney for legal advice? How much

does the doctor charge for a medical procedure, and how much does he or she accept from the plaintiff's counsel for the same treatment?

Establishing that a plaintiff was provided with medical services that were unwarranted and unnecessary can best be shown by the lack of similarly situated patients that underwent the care received by the plaintiff. The deposition notice for a treating healthcare provider should make apparent that the deponent will be asked these questions and expected to have documentation available (redacted) from other patients that were (or were not) provided similar care.

Many defense attorney associations, including DRI, maintain expert witness databases that also include testimony from treating healthcare providers. Members should always review such a database before taking (or defending) any deposition. Impeaching a treating healthcare provider with prior inconsistent deposition testimony can be catastrophic to a plaintiff's case; thus care must be given before taking a deposition to discover everything about the witness (e.g., prior trial testimony, publications, depositions, speaking engagements, among other things).

Finally, as discussed earlier, state governments have taken a much more aggressive and thorough approach to identifying and stopping fraudulent medical treatment. A review of a treating healthcare provider's state medical board license status is a practical necessity. And if counsel discovers that the conduct of a treating healthcare provider is in violation of state or federal law, then counsel should strongly consider reporting it to the appropriate authorities.

Lawyer's Ethical Obligations

Last, but certainly not least, plaintiff counsel should be reminded of their ethical obligations prohibiting the pursuit of frivolous claims. *See* Model Rule 3.1. Perhaps more importantly, lawyers have licenses to practice law, not medicine, and directing patient treatment crosses a line that would not be well received by a medical board or a state bar.

Conclusion

Attorney-directed medical treatment has become more prolific over the past several

years, resulting in fraudulent billing, excessive treatment, and dangerously invasive procedures. Defense practitioners should identify the plaintiff attorney and treating healthcare providers at the outset of a case to determine what countermeasures are needed to prevent runaway medical special damages. Defense practitioners should attempt surveillance of questionable plaintiffs before litigation, get a pre-litigation, independent medical examination, and if all else fails, seek to establish the prejudice resulting from a plaintiff's refusal to allow

a reasonable examination (including sending an evidentiary hold letter). A treating healthcare provider should be heavily researched by defense counsel and deposed thoroughly to establish improper treatment, excessive billing, bias, and inconsistent care. A plaintiff should be cross-examined about his or her subjective pre-treatment complaints and the source of any referrals for healthcare treatment. These strategies when used effectively can help combat attorney-directed medical treatment and limit exposure for the defendant.



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