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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FOURTH APPELLATE DISTRICT

DIVISION THREE

SALMA NATALIE ANDRAOS,

Plaintiff and Appellant,

v.

A. MICHAEL MOHEIMANI,

Defendant and Respondent.

G048537

(Super. Ct. No. 30-2010-00434345)

O P I N I O N

Appeal from a judgment of the Superior Court of Orange County, Ronald L. Bauer, Judge. Affirmed.

Law Offices of Mark B. Plummer and Mark B. Plummer for Plaintiff and Appellant.

Hitzke & Associates, Daniel L. Hitzke and Jason Buscaino for Defendant and Respondent.

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Salma Natlie Andraos appeals from the trial court's decision rejecting her request for a declaratory judgment extinguishing her obligation to pay A. Michael Moheimani, M.D., her orthopedist, \$1,715 for treatment he provided after she was involved in a car accident. According to plaintiff, she was a third party beneficiary of a medical services agreement between defendant and her insurance plan that would entitle defendant to only \$324 as "payment in full" for the same services. Plaintiff argued that defendant was entitled to nothing because he did not present his bill to her insurance carrier, but instead billed her directly under a medical lien agreement she claims was invalid. Plaintiff asserted no payment was due under the lien agreement because it only operated as a secondary source of payment if her insurance was unavailable, which defendant failed to utilize. She also argued the lien agreement was unenforceable because defendant obtained it with unclean hands by failing to disclose it would result in substantially higher medical costs for her. The trial court, however, reasonably could determine on the evidence presented that plaintiff did not provide her insurance information to defendant in time for him to bill her insurance company. Also, the trial court reasonably could conclude plaintiff and her lawyer elected to proceed by direct billing under the medical lien agreement instead of her insurance plan for tactical reasons in her lawsuit, which resulted in a settlement. In sum, ample evidence supports the trial court's conclusion plaintiff remained obligated to pay defendant under the medical lien, and we therefore affirm the judgment.

I

FACTUAL AND PROCEDURAL BACKGROUND

Plaintiff retained a law firm after she suffered injuries in a car accident in March 2008. The law firm referred her to a chiropractor, and the chiropractor referred

her to defendant. According to plaintiff, she provided her insurance card and insurance information to defendant's staff when she arrived at his office, as she generally does for all medical appointments. But she admitted at her deposition that she had no specific recollection of doing so this time. According to defendant, he offers new patients who are referred to him by a lawyer or otherwise contemplating personal injury litigation the option of paying for their treatment using insurance or by direct billing under a medical lien agreement. Defendant pointed to the fact plaintiff and her lawyer executed a lien agreement as proof she chose that option, including direct billing sent to the attorney for payment in full for her medical care, to be paid no later than at the time of any settlement, judgment, or verdict.

Specifically, the lien agreement provided in pertinent part: "I do hereby agree to pay for and authorize Dr. Moheimani to furnish you, my attorney, with full report(s) and statements of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the incident in which I was involved. [¶] I hereby authorize and direct you, my attorney, to pay directly to Dr. Moheimani such sums as may be due and owing him for medical service(s) . . . to adequately pay for and protect Dr. Moheimani for all of the medical expenses I have, or will incur. [¶] I fully understand that I am directly and personally responsible to Dr. Moheimani for payment of all medical bills . . . that are submitted to me for any services rendered. I acknowledge further that this agreement is made solely for Dr. Moheimani's additional protection in the event that there remains a balance due on any . . . statements for any services rendered, at the time of any settlements, judgment, award, or verdict. I direct that in the event said balance due exists, that Dr. Moheimani shall be paid at the time of the settlement, judgment, or verdict."

The lien agreement was entitled, “Standard Medical Service Lien Form,” and included a space at the top of the form for the patient’s attorney to provide his or her name and address. Plaintiff signed the form and her attorney, Mitra Chegini, later also signed the form and faxed it to defendant’s office. Defendant treated plaintiff for the injuries she received in the car accident, and his bill came to \$1715, which he forwarded directly to plaintiff’s attorney for payment. The attorney did not pay the bill while the litigation was pending, but used it to calculate plaintiff’s damages.

During the course of the underlying litigation, plaintiff changed attorneys. Plaintiff obtained a settlement of \$12,500 from the driver of the other vehicle. Plaintiff declined, however, to pay defendant’s bill from the proceeds. According to plaintiff, defendant prevented her from submitting his bill to her insurance carrier by never sending her a copy of the bill. By the time she found out her insurance had not paid the bill, it was “too late.” Nevertheless, she retained a billing specialist to prepare a medical services claim in the proper format for her insurance company because defendant still refused to do so, and she submitted the bill more than a year after her treatment. But her insurance company refused to pay it because it was not timely. Plaintiff estimates that if her insurance company had accepted the bill, it would have paid no more than \$324 as full payment for defendant’s treatment for her injuries.

Plaintiff then pursued this declaratory judgment action.

After the parties completed discovery, submitted their briefs and written evidence, including their declarations and deposition excerpts, and orally argued the case, the trial court took the matter under submission. The trial court observed in its brief, cogent, and insightful ruling the next day that plaintiff’s argument was based in part “upon the contention that [she] has the type of insurance coverage that would have

induced the defendant to accept a reduced rate for services, if this coverage had been made known at the onset of treatment. *Unfortunately, it was not.*” (Italics added.) The trial court also noted: “It may be that prior counsel wanted high invoices from the medical providers in order to argue for a larger settlement or verdict. Perhaps the plaintiff did not tell her former attorney that she had insurance coverage that might pay these bills. What we do know is that the plaintiff promised the defendant that the latter’s charges would be paid from the proceeds of her tort claim. This court will not now interfere with that agreement. . . . The declaratory judgment sought by the plaintiff is denied.” The court entered judgment accordingly, and plaintiff now appeals.

II

DISCUSSION

Plaintiff contends she is a third party beneficiary entitled to receive the reduced medical billing rates negotiated in an alleged contract between her insurance carrier (Blue Cross) and defendant. Plaintiff claims she presented evidence of her insurance to defendant in her first office visit, thereby precluding defendant from seeking payment at his standard rate based on the medical lien agreement she signed. She also argues the trial court erred in failing to allow her to rescind the lien agreement on equitable grounds because of defendant’s allegedly unclean hands in obtaining it in a deceptive manner.

According to plaintiff, the standard of review is de novo because this case turns on a “pure issue of law,” i.e., her interpretation of the medical lien agreement as merely a secondary basis for payment that was extinguished by defendant’s failure to first present his bill to Blue Cross. (See *Parnell v. Adventist Health System/West* (2005) 35 Cal.4th 595 [payment owed under insurance plan is “payment in full,”” extinguishing

patient's debt and voiding medical lien].) She also asserts de novo review applies to resolve the public policy question of whether a doctor may ignore a patient's insurance coverage to collect higher sums directly billed to the patient in the personal injury litigation process.

We conclude, however, that the substantial evidence standard of review governs this appeal because the trial court determined plaintiff did not alert defendant to her insurance coverage at the time of treatment. Under the deferential substantial evidence standard, the reviewing court must accept as true the evidence supporting the trial court's judgment, and discard unfavorable evidence; the trial court's credibility determinations are binding and the appellate court may not reweigh the evidence. (*Stokus v. Marsh* (1990) 217 Cal.App.3d 647, 656-657.)

The trial court's finding that plaintiff did not divulge her insurance information "at the onset of treatment" renders moot her legal challenges. For example, while she claims she was a third party beneficiary of an asserted medical services contract between defendant and Blue Cross, and defendant in contrast claims his only agreement with that insurance carrier was inapplicable because it pertained to workers' compensation treatment plans, the trial court did not have to resolve this issue. Nor do we. Simply put, the trial court reasonably could conclude that when plaintiff did not offer to pay for her treatment through an insurance plan, the medical lien she agreed to was not secondary to any other means of payment, and by its terms made her financially responsible for the medical treatment defendant provided.

Substantial evidence supports the trial court's conclusion plaintiff did not tender her insurance information to defendant to pay for his services. Plaintiff stated in her deposition that she *believed* she provided defendant with her insurance information

because “[e]very doctor requires paperwork when you go visit them” and “[t]hey all require insurance cards.” When asked if she gave defendant’s office staff a copy of her insurance card, she responded, “I’m sure I did because every time I go to a doctor they take my card and they usually photocopy it and they put it in their records. That’s the procedure.”

But she acknowledged she had no independent recollection of defendant or his staff requesting her insurance information. And the paperwork she filled out and submitted to his office did not include her insurance information. To the contrary, the documents included her consent to a medical lien, including express terms in the lien acknowledging her personal financial responsibility for treatment, authorizing defendant to send her medical bills to her attorney for payment, and specifying she would pay any outstanding balances by the date of a settlement, judgment, or verdict. Based on this evidence, the trial court reasonably could conclude plaintiff did not provide her insurance information to defendant, and instead consented to personal financial responsibility for her medical treatment according to the terms of the lien.

Plaintiff argues the trial court erred in concluding she was not entitled to rescind the medical lien based on defendant’s alleged unclean hands. She argues rescission was required because defendant committed fraud in failing to disclose her option to pay for medical services with insurance and that his services would cost her substantially more out of pocket than with insurance. Civil Code section 1689, subdivision (b)(1), provides for rescission “[i]f the consent of the party rescinding . . . was given by mistake, or obtained through duress, menace, fraud, or undue influence, exercised by or with the connivance of the [other] party”

The trial court reasonably could conclude defendant did not defraud plaintiff or act with unclean hands, and therefore rescission was not required for several reasons. First, viewed in the light most favorable to the trial court's decision, the evidence suggests defendant's only contract with Blue Cross pertained to treatment in workers' compensation cases, and therefore did not apply to plaintiff. Second, defendant testified at his deposition that his office policy was to ask patients whether they wanted to proceed with treatment through their insurance plan, if any, or by a medical lien in situations involving personal injury litigation. While he did not recall plaintiff personally, the medical lien both plaintiff and her attorney executed supports the trial court's conclusion she elected the lien option.

Third, while plaintiff now suggests defendant owed her a fiduciary duty as her doctor to explain the practical ramifications of proceeding in her personal injury lawsuit on a medical lien basis to support her damages claim, including the potentially higher medical bills she obligated herself to pay without insurance, these were litigation choices for her to make in consultation with her lawyer, not her medical provider. Her lawyer affixed his signature to the medical lien and faxed it back to defendant, thereby ratifying it. Presumably her lawyer explained any tactical reasons for and against proceeding in this manner, including a potentially higher recovery but with corresponding increased expenses. But if the attorney did not explain it, her doctor cannot be faulted for litigation choices over which he had no control.

Thus, plaintiff's reliance on *Moore v. Regents of University of California* (1990) 51 Cal.3d 120 is misplaced. There, the treating physician used the patient's leukemia cells for lucrative medical research without the patient's permission, but there is no similar lack of consent here. Defendant did not choose a litigation strategy and

corresponding billing method for plaintiff; rather, she and her lawyer did. Nothing in that choice furnishes any reason to overturn the judgment.¹

III

DISPOSITION

The judgment is affirmed. Respondent is entitled to his appellate costs.

ARONSON, J.

WE CONCUR:

RYLAARSDAM, ACTING P. J.

FYBEL, J.

¹ We note that if plaintiff had presented her insurance information to defendant at the outset of treatment, it would be an interesting question whether judicial estoppel would prevent her declaratory judgment claim for minimal or zero liability based on her insurance, when she claimed in the underlying litigation the higher amounts stated in defendant's direct bills as the basis for her damages claim. It would also be an interesting question whether she could rely on a third party beneficiary claim for the benefits of insurance coverage if she gave defendant her insurance information but eschewed coverage in favor of direct billing to support a higher damages claim in her lawsuit. But because the trial court found she did not alert defendant in a timely manner to any potential insurance coverage, these questions of whether she was entitled to the benefit of insurance coverage are moot, and we express no opinion on these topics.