University of Dayton Law Review

Volume 43 | Number 3 Article 4

7-1-2018

Imprecision's Terrible Toll: When Hospitals in Ohio Sue to Collect from Their Patients, Often the Loser Is the Rule of Law

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IMPRECISION'S TERRIBLE TOLL: WHEN HOSPITALS IN OHIO SUE TO COLLECT FROM THEIR PATIENTS, OFTEN THE LOSER IS THE RULE OF LAW

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I. INTRODUCTION

One practice area where business is plainly not booming is hospital collection defense. The rate of filing bill collection lawsuits by hospitals against non-paying patients has remained as robust as ever, even under health care reform. Yet, it seems few lawyers are clamoring to offer their assistance to defendants who are often not only in financial distress but probably also not in the best physical health either. Of the 113 hospital collection cases commenced in Montgomery County Common Pleas Court between April 21, 2015 and April 26, 2018, more than sixty-nine percent (seventy-eight cases) went uncontested, resulting in default judgment in favor of the hospital-plaintiffs.[1] In many of these cases, the dollar amounts awarded are staggering.

It's a shame, because in nearly all such cases, a dramatically different result is possible – or more accurately, should be possible – with the help of legal counsel. While that ought to be the case, it is not. How any effective representation of the defendants in these actions has come to seem impossible, is the subject of this article.

Section II of this article explains why the reasonable value of services rendered is the central element in hospital bill collection actions; why that element must be proven by the plaintiff; and how it is to be proven. Section

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III takes a look at the arguments commonly put forward by hospitals when they move for summary judgment without presenting any evidence of reasonable value, and demonstrates that those arguments are replete with legal error. Section IV analyzes a series of recent Ohio appellate cases and shows that the courts have fallen into those errors instead of correcting them. Finally, Section V concludes with the hope that the errors identified will not continue to spread, and also suggests a strategy for patients' attorneys to secure favorable settlements for their clients – at least until the law begins to be set right again by District Courts or the Ohio Supreme Court.

II. REASONABLE VALUE: THE CENTRAL ELEMENT IN HOSPITAL BILL COLLECTION ACTIONS

The typical hospital collection case is in the form of an action on an account, which by its nature is an action for breach of contract.[2] But, due to the circumstances that often surround hospitalization (especially uninsured or out-of-network), a hospital's action is usually founded on quasi-contract,[3] or contract implied-in-law to prevent unjust enrichment.[4] A hospital seeking to collect on a delinquent patient account can rarely point to an enforceable contract, especially when the patient's treatment comes on the heels of a medical emergency. Textbook contract formation, in such circumstances, is unlikely to occur. Even where the patient has signed an acknowledgement of financial responsibility upon admission, the absence of an express price term in such a document makes its enforceability dependent on judicial gap filling.[5] In either event, the amount the hospital will be entitled to receive will be the amount its services are worth ("*quantum meruit*"), defined as the *reasonable value* of the services rendered to the patient.[6]

It is well established that the rates hospitals charge to, and attempt to collect from, patients without insurance coverage – called "chargemaster" rates – are sharply, even absurdly, inflated when compared to the amounts they actually collect from covered patients and their insurers for the same services.[7] So much so that those chargemaster rates are practically the

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[2] Benchmark Contrs., Inc. v. Southgate Mgt., L.L.C., 10th Dist. Franklin No. 13AP-390, 2014-Ohio-1254, 38.

[3] *See, e.g.,* Hailey v. MedCorp, Inc., 6th Dist. Lucas No. L-05-1238, 2006-Ohio-4804, ¶¶ 2, 17-18.

[4] Williams v. Goodyear Aircraft Corp., 84 Ohio App. 113, 117 (9th Dist.1948).

[5] *See* Dorsey v. Contemporary Obstetrics & Gynecology, Inc., 113 Ohio App. 3d 75, 86 (2d Dist.1996) (citing RESTATEMENT (SECOND) OF CONTRACTS § 204 (AM. LAW. INST. 1981) ("When the parties to a bargain sufficiently defined to be a contract have not agreed with respect to a term which is essential to a determination of their rights and duties, a term which is reasonable in the circumstances is supplied by the court.").

[6] *See* Gioffre v. Simakis, 72 Ohio App. 3d 424, 428 (10th Dist.1991).

[7] *See, e.g.*, STEVEN BRILL, *Bitter Pill: Why Medical Bills Are Killing Us*, AMERICAN SOCIETY OF MAGAZINE EDITORS, THE BEST AMERICAN MAGAZINE WRITING 2014 213, 223, 228 (Sid Holt ed., 2014) (describing hospital chargemaster list prices as "inflated" and "exorbitant"); STEVEN BRILL, AMERICA'S BITTER PILL: MONEY, POLITICS, BACKROOM DEALS, AND THE FIGHT TO FIX OUR BROKEN HEALTHCARE SYSTEM 6, 221–23, 441 (2015) (chargemaster prices "outrageous," "ridiculous" in the view of several prominent hospital CEOs, and ought to be seen as "an opening bid" in a process to be "treated like the

definition of unreasonable charges. Nonetheless, cases from all over Ohio demonstrate that even when defendants are represented by counsel, the hospital plaintiff usually comes out with a judgment awarding it the full chargemaster rate, plus interest.[8] How is it that hospital collection actions turned into such a slam-dunk for plaintiffs, while defense of the patients has come to be so avoided?

The answer seems to be that simply assigning the burden of proof in these cases to the plaintiffs, as would be proper, has become a stumbling block for some Ohio courts, including several of our Courts of Appeal.[9] Bad writing, careless lawyering, and the failure to actually read cases that are confidently cited as precedent, have converged to create a situation where courts handling hospital collection actions are now placing the evidentiary burden squarely on the defendant, with no legal justification for doing so.[10] In effect there has been a seismic change in the law, one that has gone unnoticed, that threatens to bring about tremendous injustice – and no valid reasoning exists to support such a radical revision of the law.

Let us begin with what is well-established and familiar: "He who affirms must prove."[11] A party seeking damages under quasi-contract must of course prove each element of the cause of action for unjust enrichment: "'(1) a benefit conferred by a plaintiff upon a defendant; (2) knowledge by the defendant of the benefit; and (3) retention of the benefit by the defendant under circumstances where it would be unjust to do so without payment.'"[12] The plaintiff must also prove its damages – must prove, in other words, that the amount of compensation it is seeking is reasonable.[13] As Judge Archer

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proverbial Pakistani rug market"); George A. Nation III, *Hospital Chargemaster Insanity: Heeling the Healers*, 43 PEPP. L. REV. 745, 748-50, 756, 764 (2016) ("insanely high," "fictitious," "ludicrously high," "exorbitant," "outrageous," "ridiculously high," "so unreasonably high"; also pointing out that many hospital administrators agree); Erin C. Fuse Brown, *Irrational Hospital Pricing*, 14 HOUS. J. HEALTH L. & POLICY 11, 14-15, 19 (2014) ("inflated," "almost always significantly higher than a hospital's costs," and have drawn "criticism over . . . their dizzying heights"); Morgan Housel, *Anatomy of the World's Most Insane Health Care Billing System*, THE MOTLEY FOOL (May 14, 2013), *available at* https://www.fool.com/investing/general/2013/05/14/anatomy-of-the-worlds-most-insane-health-care-bill.aspx ("absurdly inflated prices").

[8] *See infra* Section III, and cases cited therein. *See generally* Barak D. Richman, et al., *Battling the Chargemaster: A Simple Remedy to Balance Billing for Unavoidable Out-of-Network Care*, 23 AM. J. MANAGED CARE e100 (Apr. 2017), *available at* https://www.researchgate.net/profile/Barak_Richman/publication/316943806_Battling_the_chargemaster_A_simple_remedy_to_balance_billing_for_unavoidable_out-of-network_care/links/5b1e91b7a6fdcca67b69c5c0/Battling-the-chargemaster-A-simple-remedy-to-balance-billing-for-unavoidable-out-of-network-care.pdf?origin=publication_detail.

[9] *See infra* Section IV.

[10] *See infra* Sections III-IV.

[11] Schaffer v. Donegan, 66 Ohio App. 3d 528, 534 (2d Dist.1990) (citing Martin v. Columbus, 101 Ohio St. 1, 8–9 (1920)).

[12] HAD Ents. v. Galloway, 192 Ohio App. 3d 133, 2011-Ohio-57, 948 N.E.2d 473, at ¶ 8 (4th Dist.) (quoting Hambleton v. R.G. Barry Corp., 12 Ohio St. 3d 179, 183 (1984)).

[13] Stoebermann v. Beacon Journal Publ'g Co., 177 Ohio App. 3d 360, 2008-Ohio-3769, 894 N.E.2d 750, at ¶ 29 (9th Dist.) (citing Watterson v. King, 166 Ohio App. 3d 704, 2006-Ohio-2305, 852 N.E.2d 1278, at ¶ 16(5th Dist.); Fox & Assoc. Co. L.P.A. v. Purdon, 44 Ohio St.3d 69, 72 (1989)); Hailey v. MedCorp, Inc., 6th Dist. Lucas No. L-05-1238, 2006-Ohio-4804, at ¶ 21 (citing Gioffre v. Simakis, 72 Ohio App. 3d 424, 428 (10th Dist.1991).); Herkins v. Perrin, 55 Ohio Law Abs. 328, 331 (2d Dist.1949).

Reilly of the Tenth District explained:

> [O]ne seeking to recover the reasonable value of his services in quantum meruit cannot rely on the alleged terms of a contract which have not been otherwise proven. The measure of recovery is the reasonable value of the services rendered, which must be proven by competent credible evidence presented at trial . . . The party asserting a claim in quantum meruit has the burden of proof and must introduce evidence as to the reasonable value of the services rendered.[14]

In quasi-contract actions in Ohio, the reasonable value of a plaintiff's services is defined as "that compensation usually paid for like services at the time and place when and where these were rendered"[15] – a rule that goes back so far that to call it well-established or longstanding feels like an understatement. A court seeking to determine the amount by which a defendant has been unjustly enriched by the plaintiff's services will obviously want evidence pointing to some objective measure of their value within the relevant market.[16] This market-centered principle should be familiar to any attorney who has pursued an action in *quantum meruit* to collect a fee from a client. Under the Ohio Rules of Professional Conduct, one of the factors that must be considered in determining a reasonable attorney's fee is "the fee customarily charged in the locality for similar legal services."[17]

In the effort to determine the reasonable value of professional services in a case of unjust enrichment, it would make little sense to simply inquire what the value is to the defendant (who will of course deny that they are of any value to him; after all, he is trying to avoid any legal obligation to pay). But it is just as nonsensical to look only at the plaintiff's customary charge for its services and end the inquiry there. The amounts that the plaintiff ordinarily receives from its customers, pursuant to its contracts with them, may be relevant to the issue of reasonable value; but it is insufficient to fully answer the question, as such evidence may only demonstrate what a small handful of actors within the broader market for like services believes to be a reasonable price. A court must have evidence, not merely of the amounts customarily charged by the plaintiff for its services, and accepted as full payment, but also evidence showing how those amounts fit within a market that comprises other service providers and those other providers' customers.

> [T]he reasonable value [of professional services] must be determined in great measure by proof of what such

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[14] *Gioffre*, 72 Ohio App. 3d at 428.

[15] Bagley v. Bates, Wright 705, 706 (Ohio 1834).

[16] *See* RESTATEMENT (THIRD) OF RESTITUTION AND UNJUST ENRICHMENT § 20 cmt. c (AM. LAW. INST. 2011).

[17] OHIO PROF. COND. R. 1.5(a)(3).

> services rendered by men [sic] of skill in their profession command at the place where they are rendered; that is, what sum in accordance with the usage and practice of those who render such service and those for whom they are rendered is asked and paid therefor.[18]

This has been the rule applied in medical bill collection cases in many jurisdictions.[19] Ohio courts too have held that "[t]he value of medical services, as a general rule, is to be ascertained and fixed by the usual price paid for like services at the time and place of performance."[20] Given the realities of the contemporary marketplace for health services, and in light of the foregoing rules, in order for a court to determine if the amount billed by a physician, surgeon, or hospital for medical services is reasonable, there must be evidence comprising not only amounts billed but amounts received; not only between the plaintiff and its own patients and their insurers (amounts which vary widely), but also as to other providers of similar medical services in the same geographic area. The testimony of a qualified expert can satisfy this requirement,[21] but it is the plaintiff who must present the court with such

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[18] Saffin v. Thomas, 8 Ohio C.C. 253, 254–55 (1894).

[19] *See* 70 C.J.S. *Physicians, Surgeons, and Other Health-Care Providers* § 192 (2005) ("A physician is entitled to recover the ordinary and reasonable charges usually made by members of the same profession, of similar standing, for services such as those rendered."). *See also* Colomar v. Mercy Hosp., Inc., 461 F. Supp. 2d 1265, 1270–71 (S.D. Fla. 2006) (describing "what the market charges for similar services [a]s one relevant measure of reasonableness," and cautioning: "While evidence of what others in the market charge for similar services is a necessary factor in the analysis, it is not a sufficient one in and of itself."); Howard v. Willis-Knighton Med. Ctr., 924 So. 2d 1245, 1254 (La. App. 2006) (describing the "'reasonable value' of medical goods and services provided by a hospital to a patient . . . is to be determined by considering the hospital's internal factors as well as the similar charges of other hospitals in the community[.]"); Doe v. HCA Health Svcs. of Tenn., Inc., 46 S.W.3d 191, 198 (Tenn. 2001) (same); St. Luke's Episcopal-Presbyterian Hosp. v. Underwood, 957 S.W.2d 496, 498 (Mo. Ct. App. 1997) (stating hospital's credit assistant testified that "the hospital established its charges [by using] a periodic survey of hospitals within the area to determine if its charges were in line with those of other hospitals."); Galloway v. Methodist Hosp., Inc., 658 N.E.2d 611, 614 (Ind. Ct. App. 1995) (crediting testimony of hospital's controller, who testified that its "charges were comparable to other facilities in northwest Indiana."); Victory Mem. Hosp. v. Rice, 493 N.E.2d 117, 120 (Ill. App. Ct. 1986) ("any assessment of the reasonableness of a private hospital's charges must include consideration and recognition of the particular hospital's costs, functions and services to make a valid determination of whether such charges were reasonable for that hospital alone or compared to the charges of other area hospitals."); Ellis Hosp. v. Little, 409 N.Y.S.2d 459, 461–62 (N.Y. 1978) (describing assistant comptroller of another hospital in the same metropolitan area as plaintiff, who was familiar with how charges were set by area hospitals, testified that the charges for the plaintiff's services were similar to those at his own hospital).

[20] Chiropractic Clinic of Solon v. Kutsko, 8th Dist. Cuyahoga No. 70119, 1996 Ohio App. LEXIS 5445, *9 (Dec. 5, 1996) (*citing* Sabroske v. Williamson, 79 Ohio L. Abs. 257, 155 N.E.2d 286 (C.P.1958)).

[21] Indeed, the hospital may seek to qualify the employee in charge of its patient account records as an expert able to testify as to the reasonable value of the hospital's services. *See Underwood*, 957 S.W.2d at 498 (hospital's credit assistant who "testified that she was familiar with the method by which the hospital established its charges; namely, the hospital used a periodic survey of hospitals within the area to determine if its charges were in line with those of other hospitals[]" held to be "qualified to testify on the issue of the reasonableness of the charges."); Heartland Health Sys., Inc. v. Chamberlin, 871 S.W.2d 8, 11 (Mo. Ct. App.1993) (describing testimony by hospital's financial representative, that its charges were reasonable, held sufficient where she "testified that, as part of her duties, she was familiar with the customary charges in the medical industry for services of the same type as those rendered to [the defendant]."). During the discovery phase, the disclosures required of the plaintiff in relation to such an expert witness create an opportunity for the defendant to discover, by deposition, interrogatories, or request for production, the factual basis for the expert witness's opinions. *See* OHIO R. CIV. P. 26(B)(5)(b) (LexisNexis 2018). This

evidence in order to meet its burden of proving the amount of damages it is entitled to from the defendant.

Even if it is conceded that a plaintiff's "usual" charge for its services would be in some way relevant to the question of the value of those services in the local market, and therefore admissible as some evidence of reasonable value, the same cannot be said for the fees listed in a hospital chargemaster. Those fees are not the amounts the hospital "usually" or "customarily" receives for its services, from any of its patients – insured or uninsured – or from third party payers. Therefore, hospital chargemaster rates do not meet the relevance test for admissibility, a low hurdle. Even less do they fulfill the purpose of proving, by themselves, the reasonable value of the hospital's services. A hospital seeking to collect a fee from a patient must come forward with a good deal more than its own billing statement in order to satisfy its burden of proof.

You might then expect, at the very least, that where there is no contract between a hospital and its patient, the hospital obtaining a judgment awarding it the grossly overstated chargemaster rate as compensation would be highly improbable. You would be wrong.

III. HOSPITALS MOVE FOR SUMMARY JUDGMENT, MAKE A MISHMASH OF THE LAW

In an increasingly familiar pattern, the hospital plaintiff (where its action is opposed – remember the high rate of default judgments) files its motion for summary judgment, together with the patient's billing record (filed under seal) and an affidavit from a hospital employee such as a patient accounts manager or other person in a similar position. The affidavit essentially attests under oath to facts establishing that the hospital's billing records are admissible as business records and that the amount demanded in the lawsuit is the same as the amount shown on the billing statement. Nothing suggesting that the hospital's billing specialist could be qualified to give expert testimony on the billing practices of other area hospitals, and of course, no mention of the kinds of comparisons such an expert witness would be able to make. An accompanying memorandum in support of summary judgment then seeks to demonstrate that, by presenting its bill and its affidavit, the hospital has carried its initial burden – has proven that the amount it is demanding is the reasonable value of its services – and is therefore entitled to judgment as a matter of law unless the defendant comes forward with evidence proving the hospital's bill is unreasonable. The arguments put forward by the hospitals instead only demonstrate that our courts have sadly lost their way.

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would include whatever data is available to the hospital employee on the amounts charged and received by other hospitals in the area, or alternatively, could expose the insufficiency of such data and the flimsiness of the factual basis for the expert's opinions.

The argument presented in the typical hospital-plaintiff's motion for summary judgment[22] relies primarily on *Jaques v. Manton*,[23] *Robinson v. Bates*,[24] or *Wagner v. McDaniels*[25] to shift the burden of production onto the defendant. In each of those cases, the Supreme Court of Ohio has said: "Proof of the amount paid or the amount of the bill rendered and of the nature of the services performed constitutes prima facie evidence of the necessity and reasonableness of the charges for medical and hospital services."[26] Simply by being introduced in evidence, a hospital bill all but proves its own reasonableness. In a bill collection case, if that holding seems surely fatal to the defendant's hope of withstanding the hospital's motion for summary judgment – indeed, if it even seems on point at all – then we need to take a closer look at what the Court was actually saying in those cases.

The fact that the element of necessity is mentioned alongside reasonableness is our first clue that something is amiss. As mentioned earlier, an action on an account is an action for breach of contract, and necessity is not an element of a breach of contract claim. The necessity of physician or hospital services is, however, an element that a personal injury plaintiff must prove in an action seeking damages from the person who caused the injury. The fact that the Ohio Supreme Court discussed both reasonableness and necessity in *Wagner*, *Robinson*, and *Jaques*, should arouse suspicion that invoking these cases in a collection action is a flagrant misapplication of their holdings.

Here is a fuller view of what the Court actually said in *Robinson*:

> In personal-injury cases, an injured party is entitled to recover necessary and reasonable expenses arising from the injury. Since those expenses include the reasonable value of the medical care required to treat the injury, the question is raised as to how to determine the reasonable value of the medical care. In Wagner, we held that "[p]roof of the amount paid or the amount of the bill rendered and of the nature of the services performed constitutes prima facie evidence of

[22] *See, e.g.*, Miami Valley Hosp. v. Newcomer, No. 2015 CV 05004, Memo. in Support of Pls.' Motion for Summary Judgment, § II (Montgomery C.P. Feb. 25, 2016), *available at* http://www.clerk.co.montgomery.oh.us/pro/; Akron Gen. Med. Ctr. v. Easterling, No. CV-2011-11-6334, Pls.' Reply Brief in Support of Motion for Summary Judgment, § II(a) (Summit C.P. Feb. 19, 2013), *available at* https://clerkweb.summitoh.net/PublicSite/Documents/sumf5000005E8.pdf; Akron Gen. Med. Ctr. v. Sunner, No. CV 2012 02 0857, Memo. in Support of Pls.' Motion for Summary Judgment, § III (Summit C.P. Nov. 7, 2012), *available at* https://clerkweb.summitoh.net/PublicSite/Documents/sume500000DF1.pdf; Riverside Methodist Hosp. v. Phillips, No. CV 20111183, Memo. in Support of Pls.' Motion for Summary Judgment, § III, (Hardin C.P. Feb. 21, 2012), *available at* http://www.hardincourts.com/cgi-bin/cdocket.cgi?pre=CVH&num=20111183&sub=&type=CV&acc=.

[23] 125 Ohio St. 3d 342, 2010-Ohio-1838, 928 N.E.2d 434.

[24] 112 Ohio St. 3d 17, 2006-Ohio-6362, 857 N.E.2d 1195.

[25] 9 Ohio St. 3d 184 (1984).

[26] *Jaques* 125 Ohio St. 3d at ¶ 5 (quoting *Wagner*, 9 Ohio St. 3d at paragraph one of the syllabus); *Robinson*, 112 Ohio St. 3d at ¶ 7 (quoting *Wagner*, 9 Ohio St. 3d).

> the necessity and reasonableness of the charges for medical and hospital services.[27]

Read in isolation, that final sentence might appear to have some application to a hospital's suit to collect from its patient, but only by wrenching its holding loose from the personal injury case context in which it arose. Like *Robinson*, *Wagner* was a personal injury case,[28] as was *Jaques*.[29] Citations to their holdings do not belong in a motion for summary judgment in a collection case. What these hospital plaintiffs are routinely doing is, to borrow Ian Millhiser's apt metaphor, citing a rule about apples to win a lawsuit about oranges.[30]

And, it is also easy to see why the *Wagner* rule, followed in *Robinson* and *Jaques*, should not be applied to a hospital bill collection case. The rationale for declaring that a hospital bill is prima facie evidence of its own reasonableness, *in a personal injury case*, is to ease the evidentiary burden on the injured plaintiff by instead placing the burden upon the person responsible for the injury to prove that the injured person's medical bills are not reasonable. The trend toward allocating the burden in this way originated in cases in which the injured plaintiff had either already paid the bill[31] or acknowledged indebtedness to the medical service provider for the amount billed.[32] In Ohio, the appropriateness of adopting a fairer allocation of the burden in a personal injury case was first suggested in a concurrence by Justice Bell in 1957,[33] and before the Court adopted it in *Wagner* the General Assembly did so with a statute, Section 2317.421 of the Ohio Revised Code, enacted in 1970.[34] The text of the statute plainly precludes any application of its rule to a hospital bill collection case:

> *In an action for damages arising from personal injury or wrongful death*, a written bill or statement, or any relevant portion thereof, itemized by date, type of service

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[27] *Robinson*, 112 Ohio St. 3d at ¶ 7 (emphasis and internal citations omitted).

[28] *Wagner*, 9 Ohio St. 3d at 184 n.1 (compensatory damages awarded to plaintiff were for "personal psychological injury").

[29] *Jaques*, 125 Ohio St. 3d at ¶ 1.

[30] Ian Millhiser, *The False Statement Of Fact That Forms The Backbone Of John Boehner's Anti-Obama Lawsuit*, THINKPROGRESS (July 14, 2014), https://thinkprogress.org/the-false-statement-of-fact-that-forms-the-backbone-of-john-boehners-anti-obama-lawsuit-ac6370a69ee2/.

[31] *See* Barlow v. Salt Lake & Utah R.R. Co., 194 P. 665, 674 (Utah 1920) ("When the bill of a physician is paid it is prima facie evidence of its reasonableness."); Louisville & I.R. Co. v. Frazee, 200 S.W. 948, 949 (Ky. Ct. App. 1918) (describing evidence related to medical services, "coupled with the further proof that they were all necessary and that the bills therefor had actually been paid, was sufficient to make out a prima facie case that the charges were reasonable") (cited in Gerbing v. McDonald, 229 N.W. 860, 862 (Wis. 1930)); Morsemann v. Manhattan Ry. Co., 10 N.Y.S. 105, 106 (N.Y. 1890) ("The present case is different because plaintiff has paid the doctors' bills.").

[32] *See* Frankfort & Versailles Traction Co. v. Hulette, 106 S.W. 1193, 1195 (Ky. Ct. App. 1908) ("The plaintiff testified . . . that he had not paid his doctors' bills, but owed them."); Abbitt v. St. Louis Transit Co., 79 S.W. 496, 497 (Mo. Ct. App. 1904) ("There was no testimony that the charge was reasonable, but the presentation of the bill and its payment or settlement by note or otherwise, was some evidence that it was reasonable.").

[33] DeTunno v. Shull, 166 Ohio St. 365, 377 (1957) (Bell, J., concurring).

[34] OHIO REV. CODE ANN. § 2317.421 (LexisNexis 2018).

> rendered, and charge, shall, if otherwise admissible, be prima-facie evidence of the reasonableness of any charges and fees stated therein for medication and prosthetic devices furnished, or medical, dental, hospital, and funeral services rendered by the person, firm, or corporation issuing such bill or statement[.][35]

The introductory clause demonstrates the statute's purpose: To shift the burden of production, on the question of the reasonableness of medical expenses, from an injured plaintiff onto the defendant whose injurious conduct caused the medical expenses to be incurred. It also makes obvious what the statute does not do: its text cannot be used to support any similar easing of the plaintiff's burden of production where the plaintiff is a hospital bringing a collection action against a patient. The benefit of the statute's burden-shifting goes to the party that paid the bill, or is obligated to pay it, and not to the party that issued it. This statute is as unhelpful to a hospital in a bill collection case as the personal injury rulings set forth in *Wagner*, *Robinson* and *Jaques*. Of course, those opinions included language explicitly confining their holdings to personal injury cases, and that has not prevented hospital plaintiffs from using those cases to try to shift their evidentiary burden onto their opponents. This statute has been abused in similar fashion.

To be sure, where the patient sued by a hospital has already brought a personal injury action against a tortfeasor and obtained a judgment requiring that person to pay the resulting medical bills, the judgment from the personal injury action, finding his medical expenses to be necessary and reasonable, would probably carry through to any subsequent collection action brought by the hospital against the patient as a matter of issue preclusion or collateral estoppel on the element of reasonableness. It would certainly be difficult for the patient as defendant to resist a collection effort by arguing that the hospital's bill is unreasonable, when the same patient, as a successful tort plaintiff, has a judgment in hand saying the opposite. But, in some cases, hospitals are attempting to make an end-run around issue preclusion, arguing, without citation to authority, that the patient is estopped from raising the question of reasonableness in their collection action simply on account of the patient's having introduced the hospital's bill in a personal injury proceeding, whether a final judgment has been issued or not.[36] Of course, this is not how issue preclusion works, which is perhaps why the doctrine itself is not invoked by name, nor is any relevant case law cited in the hospitals' briefs.

Citations to irrelevant cases, an inapposite statute, and exaggerated issue preclusion have become depressingly routine in hospital plaintiffs'

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[35] *Id.* (emphasis added).

[36] *See, e.g.*, Akron Gen. Med. Ctr. v. Easterling, No. CV-2011-11-6334, Pls.' Reply Brief in Support of Motion for Summary Judgment, §§ II(a)-(b) (Summit C.P. Feb. 19, 2013), *available at* https://clerkweb.summitoh.net/PublicSite/Documents/sumf5000005E8.pdf.

summary judgment briefs. Even more disheartening than the fact that hospitals put forward such fault-ridden legal arguments, is the fact that they usually win. This situation is, ironically, even more likely to bring discredit on the legal profession than the many cases the hospitals win by default. Going forward, attorneys representing patients in such actions would benefit from a sort of blueprint or how-to manual pointing up the defects and vulnerabilities in the plaintiffs' usual arguments, and that is what this article is meant to provide. Much damage, though, has already been done.

IV. THE TARNISH OF LEGAL ERROR FINDS ITS WAY INTO APPELLATE OPINIONS

Regrettably, the faulty legal reasoning on display in these cases – trial courts deciding bill collection actions on the basis of a burden-shifting doctrine that belongs to personal injury actions and sometimes using something that looks like issue preclusion where it does not apply – has not been corrected in our state's courts of appeals but instead has been taken up and propagated by several of them.

The first time it happened was in 2005. In *St. Joseph's Hospital v. Hoyt*,[37] the Fourth District Court of Appeals reviewed a grant of summary judgment to a hospital in its action to collect a $1,000 fee from the defendant, who had been treated in the hospital's emergency room.[38] As an initial matter, it would be helpful for readers if the court of appeals in its opinion would identify the hospital's cause of action by name before launching into its analysis. It does not.

A search of the lower court's online docket indicates that this was an action on an account,[39] but it is not clear if the account was predicated on express contract or quasi-contract. At any rate, the defendant attempted to resist summary judgment by arguing that the hospital's motion lacked any evidence of medical necessity,[40] which seems to rule out express contract and tip the scales toward quasi-contract. The defendant seems to be saying that, because the hospital had produced no evidence that the services rendered were medically necessary, it failed to prove the third element of an action for quasi-contract: the existence of circumstances where it would be unjust to retain the benefit of the services without payment.[41] The only evidence of medical necessity before the court was the affidavit of the hospital's records keeper, who merely made a conclusory assertion that the services rendered were

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[37] 4th Dist. Washington No. 04CA20,2005-Ohio-480.

[38] *Id.* at ¶ 1.

[39] Docket Entry, St. Joseph's Hosp. v. Hoyt, No. CVF 0300816 (Marietta M.C. Aug. 26, 2003) ("$1000.00/ ACCOUNT"), *available at* https://www.mariettacourt.com/recordSearch.php?k=case8420N93ITz0YBovgwJyDEQ3hzCc9o0qjXLXDVU55sasA914833784660001846700557298759803821134573522704333849878186842150723159550459 82.

[40] *Hoyt*, 2005-Ohio-480 at ¶ 6.

[41] *See supra* Section II and text accompanying note 13.

necessary; the affidavit also "incorporated. . . a statement of the expenses and a listing of the services rendered."[42] The court of appeals concluded that this is sufficient to prove medical necessity, and the way it reached that conclusion parallels the faulty legal reasoning on the question of reasonableness in hospital summary judgment briefs discussed in the previous section. The *Hoyt* case predates them, and it seems to have opened the door for what followed.

It is easy to see where the *Hoyt* court's analysis went astray: to the careful reader, what stands out is its explanation that the hospital "sought to recover medical expenses it incurred when rendering medical services to Hoyt."[43] This is a peculiar way to describe the plaintiff's cause of action – using vocabulary that would be appropriate to describe the cause of action in a personal injury case. It is a personal injury plaintiff who typically seeks to recover the "medical expenses" it has "incurred"; in contrast, a hospital in a collection action is seeking the reasonable value of its services, not its "expenses." But by swapping inappropriate terms for appropriate ones, the Fourth District has set the stage for the application of a manifestly inappropriate legal doctrine. That doctrine is the one pulled from *Wagner v. McDaniels*: "Proof of the amount paid or the amount of the bill rendered and of the nature of the services performed constitutes prima facie evidence of the necessity and reasonableness of the charges for medical and hospital services."[44] Again, this rule should only be applied to personal injury cases, as its purpose is to shift the burden onto the person liable for the plaintiff's injury, to present evidence either that the services are not medically necessary or that the expenses incurred are not reasonable. Applied to a case like *Hoyt*, the rule is distorted in a manner that works against the interests of justice: A hospital moving for summary judgment in a collection case can be deemed to have carried its initial burden by presenting nothing more than its billing statement (with or without a conclusory affidavit from a hospital employee), and the onerous burden of *dis*proving what the plaintiff has not proven by any relevant evidence whatsoever is foisted onto the defendant.

In the decade-plus that has passed since the *Hoyt* decision, it has not been cited in any reported case for this holding. As a belief though, hospital attorneys saw the opportunity presented by the *Hoyt* court's lapse in reasoning.[45] In recent years, several additional cases have gone before Ohio

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[42] *Hoyt*, 2005-Ohio-480 at ¶ 5.

[43] *Id.* at ¶ 18.

[44] *Id.* (quoting *Wagner v. McDaniels*, 9 Ohio St. 3d 184, paragraph one of the syllabus (1984)).

[45] *Hoyt* is the case habitually cited by hospitals in their summary judgment briefs. *See, e.g.*, Miami Valley Hosp. v. Newcomer, No. 2015 CV 05004, Memo. in Support of Pls.' Motion for Summary Judgment, § II (Montgomery C.P. Feb. 25, 2016), *available at* http://www.clerk.co.montgomery.oh.us/pro/; Miami Valley Hosp. v. Gonder, No. 2012 CV 08745, Memo. in Support of Pls.' Motion for Summary Judgment, § III (Montgomery C.P. July 22, 2013), *available at* http://www.clerk.co.montgomery.oh. us/pro/; Miami Valley Hosp. v. Hercutt, No. 2013 CV 00588, Memorandum in Support of Pls.' Motion for Summary Judgment, § III (Montgomery C.P. July 5, 2013), *available at* http://www.

district courts, and the decisions in those cases replicate Hoyt's error.

In *Miami Valley Hospital v. Middleton*,[46] the Second District Court of Appeals reviewed a grant of summary judgment in favor of a hospital in its action to collect slightly over $5,500 from a patient who received emergency medical treatment after being injured in an automobile accident.[47] In the discovery phase, the defendant failed to respond to the hospital's requests for admissions, and because of that, every element of the hospital's quasi-contract action[48] was established[49] pursuant to Civ. R. 36(A)(1)[50], except the dollar amount for which he was liable.[51] He, therefore, opposed summary judgment by "argu[ing] that the trial court had no evidence of the 'reasonableness' of the charges in the hospital's bill[.]"[52] Indeed, the only evidence before the court on the hospital's motion for summary judgment was the hospital's bill and an "Affidavit Evidencing Account Balance."[53]

The *Middleton* court held that the bill by itself was *prima facie* evidence of its own reasonableness and therefore sufficient for the trial court to find that the plaintiff had carried its initial burden.[54] The court was then able to affirm the grant of summary judgment on the basis of the patient's failure to rebut by presenting evidence that the hospital's bill was unreasonable.[55] The court reached this conclusion based, of course, on the personal injury rules from *Robinson v. Bates*, *Wagner v. McDaniels*, and O.R.C. § 2317.421 – none of which applies to case like this one. Most surprisingly, the Second District judges actually demonstrate elsewhere in their opinion that they understand that personal injury case holdings do not apply to a collection case like the one before them.[56] Why they failed to

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clerk.co.montgomery.oh.us/pro/; Akron Gen. Med. Ctr. v. Sunner, No. CV 2012 02 0857, Memo. in Support of Pls.' Motion for Summary Judgment, § III (Summit C.P. Nov. 7, 2012), *available at* https://clerkweb.summitoh.net/PublicSite/Documents/sume500000DF1.pdf; Riverside Methodist Hosp. v. Phillips, No. CV 20111183, Memo. in Support of Pls.' Motion for Summary Judgment, § III, (Hardin C.P. Feb. 21, 2012), *available at* http://www.hardincourts.com/cgi-bin/cdocket.cgi?pre=CVH&num=20111183&sub=&type=CV&acc=.

[46] 2d Dist. Montgomery No. 24240, 2011-Ohio-5069.

[47] *Id.* at ¶ 3.

[48] *Id.* at ¶ 16. Here again, as in *Hoyt*, the court of appeals does not expressly identify the hospital's cause of action as founded on quasi-contract; instead the cause of action must be pieced together by the careful reader. Only at the end of a lengthy footnote does the court mention that the action before it "is based on contract." The court then proceeds to discuss the element of reasonableness, a quasi-contract element which has no place in an action to enforce an express contract.

[49] *Id.*

[50] OHIO R. CIV. PRO 36(A)(1) states:

> The matter is admitted unless, within a period designated in the request, not less than twenty-eight days after service of the request or within such shorter or longer time as the court may allow, the party to whom the request is directed serves upon the party requesting the admission a written answer or objection addressed to the matter, signed by the party or by the party's attorney.

[51] *Middleton*, 2011-Ohio-5069 at ¶ 17.

[52] *Id.* at ¶ 19.

[53] *Id.* at ¶ 7.

[54] *Id.* at ¶ 22.

[55] *Id.*

[56] *Id.* at ¶ 27.

recognize the very same error being committed in their own analysis is puzzling.

Besides the hodge-podge of citations to legal rules meant for personal injury cases, the *Middleton* court also relies on one hospital bill collection case, *St. Vincent Medical Center v. Sader*,[57] from which it derives the following assertion: "One Ohio court has said that '[a] hospital is entitled to the presumption that the reasonable value of the services rendered is its customary charge.'"[58] There is a problem with that assertion: The Sader court didn't say that. Notice that the *Middleton* court's quotation of *Sader* has brackets enclosing the first word, indicating a substitution. One might assume that the substitution was necessary to change an uppercase letter to lower case. In fact, the substitution changed the definite article ("the") that was used in the original to an indefinite article.[59] In doing so, the *Middleton* court altered the meaning of the quoted sentence.

What the *Sader* court actually said was not that *a* hospital, but only the hospital that was a party in the case – St. Vincent Medical Center – was entitled to that presumption in its favor, and reading the case reveals the reason why.[60] The issue before the court was the motion for summary judgment brought by third-party defendant Cincinnati Equitable Insurance Company, and the court was treating the hospital as an adverse party,[61] entitled to evidentiary presumptions in its favor.[62] The insurer overcame the presumption in favor of the hospital by "submitt[ing] an affidavit from an independent medical claims review coordinator who averred that, *based on bills submitted by other medical providers in Northern Ohio*, St. Vincent's charges were 'excessive and unreasonable.'"[63] In other words, the *Sader* court actually applied the appropriate rule of decision on the question of reasonable value.

But it is the imprecision in the *Sader* court's opinion that opened the door for the *Middleton* court to take a few of its words entirely out of their context. "Imprecision takes a terrible toll[,]" Justice Antonin Scalia once observed, during an interview conducted by legal writing specialist Bryan Garner.[64] "[T]he only important part about an appellate case is not who wins or loses; it's not, you know, affirmed or reversed. The important part is the opinion. And if you affirm or reverse for the wrong reason, you've done everything wrong."[65] The "terrible toll" Justice Scalia had in mind is

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[57] 100 Ohio App. 3d 379 (6th Dist. 1995).
[58] *Middleton*, 2011-Ohio-5069 at ¶ 21.
[59] *Compare id,* with *Sader*, 100 Ohio App. 3d at 384.
[60] *Sader*, 100 Ohio App. 3d at 383.
[61] *Id.*
[62] OHIO CIV. R. 56(C).
[63] *Sader*, 100 Ohio App. 3d at 382 (emphasis added).
[64] Bryan A. Garner, Interview, *Justice Antonin Scalia*, 13 SCRIBES J. LEG. WRITING 51, 54 (2010).
[65] *Id.*

apparently the toll on lower court judges and attorneys whose work is sometimes made more difficult when the opinions they are bound to follow are written without clarity.[66] Worse still, in my view, is the toll on parties when bad writing produces bad law. Retracing the progression of erroneous ideas, from the sources cited by the *Sader* court, to the *Sader* opinion itself, to the Second District's opinion in *Middleton*, provides a case in point.

The *Sader* case arose when the hospital sued its patient to collect the unpaid portion of its bill, and the patient brought in his insurer on a third-party complaint.[67] There were motions for summary judgment by the plaintiff against the defendant, by the defendant against both the plaintiff and the third-party defendant, and by the third-party defendant against the defendant as third-party plaintiff—none of which the court of appeals disentangles effectively in its writing.[68] From this haze emerges the court's treatment of the hospital as the adverse party, entitled to presumptions in its favor, when analyzing the insurer's motion for summary judgment – even though its motion was made against the patient, not against the hospital.[69]

As noted in *Middleton*, the *Sader* court uncovered a precedent that seemed to support that inclination, citing *Wood v. Elzoheary*,[70] for the proposition that a hospital is entitled to the presumption that its customary charge is reasonable.[71] But the *Sader* court seems oddly unsure of itself in declaring this principle of law *Elzoheary* purportedly stands for: "A medical provider *may be* entitled to a presumption that its customary fees are reasonable," the *Sader* court hesitantly announces.[72] As it turns out, there is good reason for the court's hesitancy: *Elzoheary* was a personal injury case,[73] and its holding is a paraphrase describing the operation of the statute discussed earlier, O.R.C. § 2317.421, to such a case.[74] Under the statute, it is not the hospital itself, but the hospital's billing statement that might be described as "entitled to" an evidentiary presumption in its favor,[75] but that presumption operates only "[i]n an action for damages arising from personal injury or wrongful death"[76] – not in a bill-collection case.

While the *Sader* court seems to have been appropriately reticent in

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[66] *Id.*

[67] *Sader*, 100 Ohio App. 3d at 381.

[68] *See generally id.*

[69] *Id.*

[70] 11 Ohio App. 3d 27 (8th Dist. 1983).

[71] *Sader*, 100 Ohio App. 3d at 383 (*citing Elzoheary*, 11 Ohio App. 3d at 28).

[72] *Id.* (emphasis added).

[73] *Elzoheary*, 11 Ohio App. 3d at 27–28.

[74] *Id.* at 28 ("R.C. 2317.421 causes [medical bills] to be prima facie evidence of their reasonableness, while affording opposing counsel an opportunity to challenge their reasonableness with contrary evidence.").

[75] *See, e.g.*, Stiver v. Miami Valley Cable Council, 105 Ohio App. 3d 313, 320 (2d Dist. 1995) (stating that it is bills for medical services that "enjoy the benefit of the rebuttable presumption of reasonableness" under § 2317.421).

[76] OHIO REV. CODE. ANN § 2317.421 (LexisNexis 2018).

their use of *Elzoheary*, the Second District in *Middleton* elevated *Sader's* tentative pronouncement and enshrined its error as law. What began with one court paraphrasing a personal injury statute, then another court using that paraphrase completely out of context to justify construing summary judgment evidence in favor of a party other than the party against whom the motion was made, culminated with the *Middleton* court using those courts' words to announce a rule that never before existed. This sequence of events upended the established law of hospital collection actions. All of this could have been avoided by actually reading the cases, rather than just skimming through them for a few helpful-sounding phrases to extract.

Its errors apparently unnoticed, *Middleton* was followed a few months later in the First District Court of Appeals. In *University Hospital v. Campbell*,[77] it too held that rendering summary judgment in favor of a hospital in a bill collection case was proper, where the hospital presented nothing more than its billing statements and "an affidavit stating that Campbell owed the hospital the amounts specified in the statements."[78] Which is to say, the hospital presented no evidence actually establishing that the amount it was trying to collect from the patient for its services was reasonable. Announcing that it too, like the *Middleton* court, would view a hospital as "entitled to a presumption that the value of the services rendered is the amount of its customary charge[,]"[79] the court thus relieved the hospital of its initial burden. (It also sidestepped the question, whether the rates billed to the uninsured ought to be accepted as "customary.") We can now add the First District to the list of jurisdictions where there is in effect no burden placed on a hospital to prove that its charges are reasonable when it brings a bill collection case. Under a proper application of the law to the facts set forth in *Campbell*, no burden of proof should have been placed upon the patient as non-moving party; nonetheless, the court indeed affirmed summary judgment on the grounds that the patient "presented no competent evidence to demonstrate that the charges were excessive."[80] And, just as the Second District did in *Middleton*, the *Campbell* court observed, apparently without irony, that it would be improper for the holding in a personal injury case like *Robinson v. Bates* to be "extended . . . beyond its proper scope"[81]—even while the court was doing exactly that.

In *Riverside Methodist Hospital v. Phillips*,[82] yet another court, this time the Third District Court of Appeals, followed in the path created by the First and Second Districts and issued a ruling that similarly flipped the parties'

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[77] 1st Dist. Hamilton No. C-110285, 2012-Ohio-1909.
[78] *Id.* at ¶ 12.
[79] *Id.* at ¶ 11.
[80] *Id.* at ¶ 12.
[81] *Id.* at ¶ 16 (declining to follow Akron Gen. Med. Ctr. v. Welms, 160 Ohio Misc. 2d 1, 2010-Ohio-5539, 937 N.E.2d 1106 (C.P.)).
[82] 3d Dist. Hardin No. 6-12-14, 2013-Ohio-423.

respective evidentiary burdens. In this case the defendant, a surgery patient covered by insurance, was billed nearly $52,000[83] after her insurer denied coverage (possibly due to a failure by the hospital to submit a satisfactory set of patient medical records).[84] The bill remained unpaid, and Riverside Methodist filed suit.[85] When the hospital moved for summary judgment neither of its two supporting affidavits made even the slightest gesture toward addressing the question of reasonable value.[86] Instead, the affidavits aimed only to "corroborate the amount of the charges" in Phillips's hospital bill.[87] The hospital argued, as the others had, that its bill by itself "is prima facie evidence of reasonableness of the charges and sufficient for a grant of summary judgment" unless the defendant were to present contrary evidence.[88] The appeals court agreed, and just as in the other cases we've looked at, it based its analysis on personal injury rulings (including *Robinson* and *Elzoheary*), Section 2317.421, and the poorly-written opinion in *Sader*.[89] As in the earlier cases, the *Phillips* court's opinion completely fails to explain why legal rules for personal injury litigation would have any relevance to a bill collection case, especially where, as here, there is nothing to indicate the patient might have had a personal injury claim against anyone. Ms. Phillips had spinal surgery which was planned weeks, at least, in advance; the opinion makes no mention of any injury.[90] "Phillips admitted," the court somberly informs us, "that she did not compare the charges contained in Riverside's bill to those of other hospitals[.]"[91] That this is characterized as an admission on the part of the defendant, when the type of evidence described as lacking actually ought to be presented by the plaintiff in order to meet its burden of

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[83] *Id.* at ¶ 2.

[84] Although the affidavit from the hospital's "Legal Specialist in Patient Accounts" states that the hospital "submitted medical records from this patient account to [the insurance company]" within its forty-five day deadline, it does not address the completeness of the medical records submitted, nor whether the hospital complied with the instructions set forth in the insurance company's request letter, by which it expressly reserved the right to ignore any later-received records in the case of a partial or incomplete submission. *See* Plaintiff's Motion for Summary Judgment, Exhibit C, Riverside Methodist Hosp. v. Phillips, No. 20111183 (Hardin C.P. Feb. 21, 2012) (Teresa Adkins affidavit) *available at* http://www.hardincourts.com/cgi-bin/cdocket.cgi?pre=CVH&num=20111183&sub =&type=CV&acc=; Defendant's Memorandum Contra Motion for Summary Judgment, Unnumbered Attachment, Riverside Methodist Hosp. v. Phillips, No. 20111183 (Hardin C.P. Mar. 19, 2012) (Aetna letter) *available at* http://www.hardincourts.com/cgi-bin/cdocket.cgi?pre=CVH&num=20111183&sub=&type=CV&acc=. Moreover, because the medical records request letter was sent to both the hospital and the patient, it is possible that both recipients responded by submitting records; and it is also possible that the patient sent whatever records she had more promptly than the thirty-four days that elapsed before the hospital made its submission. By the express terms of the letter, any submission made by the patient (which would likely be incomplete in itself) could have been interpreted by the insurer as authorization to proceed to review and decision, unless the patient's submission was accompanied by a notice to the insurer that records would also be forthcoming from the hospital, a fact likely beyond the patient's knowledge.

[85] *See generally Phillips*, 2013-Ohio-423.

[86] *Id.* at ¶ 17.

[87] *Id.* at ¶ 20.

[88] *Id.* at ¶ 8.

[89] *Id.* at ¶ 11.

[90] *See id.* at ¶ 18 (insurer sent medical records request letter "nearly two weeks before Phillips' scheduled surgery," indicating a request for coverage was made some time before that).

[91] *Id.* at ¶ 21.

proof, is unacceptable coming from a state appellate court. Yet, as a further demonstration of their confidence that the reasoning in *Phillips* was not unsound, the Third District would later reiterate its ruling that an "itemized medical bill is prima-facie evidence of the reasonableness of the charges," in a bill collection case where the issue was not even raised in *Mercer Health v. Welling*.[92]

Most recently, while this Article was being written, the seemingly unstoppable trend spread to yet another Ohio appellate district. In *Chaffee Chiropractic Clinic, Inc. v. Stiffler*,[93] the Ninth District Court of Appeals affirmed summary judgment in favor of a chiropractic clinic that brought an unjust enrichment claim for more than $8,000 for about five months regular chiropractic treatments upon a minor accident victim.[94] On the question of reasonable value, the court cited *Miami Valley Hospital v. Middleton*, and held that the clinic satisfied its initial burden by doing nothing more than submitting its bill with its motion for summary judgment.[95] The court then ruled that the clinic was entitled to summary judgment because the defendants (the victim and her parents) "did not present any evidence regarding the amount charged by other chiropractors in the area or otherwise present any evidence that the fees charged by Chaffee Chiropractic were unreasonable."[96] Again the fault is said to lie with the defendants for failure to perform the investigative legwork that ought to be expected from the plaintiff, if in fact it is "he who affirms" who "must prove."[97] And again, the question of the parties' relative burdens is turned completely on its head with no supporting legal authority that can withstand careful scrutiny. With the Ninth District now joining the First, Second, Third and Fourth, a potentially devastating error in legal reasoning has now been endorsed in judicial districts that include forty-two of Ohio's eighty-eight counties and cover about thirty-eight percent of the state's population.

V. CONCLUSION

Ohio's courts of appeals have now created a situation where even having a capable advocate on their side is no defense for the poorest medical patients against collection actions that have now been transformed, through unchecked legal error, into no-evidence-required slam-dunks for hospitals and other medical service providers. But, this Article has been written in the hope that our judiciary's drift into error can still be reversed. Seven courts of appeal have yet to add their voices and could begin to set things right. It is

[92] 3d Dist. Mercer No. 10-14-05, 2014-Ohio-5626, ¶ 22 n.3.

[93] 9th Dist. Wayne No. 16AP0033, 2017-Ohio-7790.

[94] *Id.* at ¶ 4–5 (treatments not covered by third party's insurance company began Nov. 2012 and ended Apr. 22, 2013).

[95] *Id.* at ¶ 29.

[96] *Id.* at ¶ 31.

[97] *See generally supra* Sections II, III.

possible for a patient sued by a hospital in a collection action to receive a favorable ruling from a court in one of those judicial districts (and also conceivably possible that if new cases were brought before the courts that decided *Hoyt*, *Middleton*, *Campbell*, *Phillips*, and *Stiffler*, those courts might recognize the errors in those cases and overrule them).[98]

For the attorney representing a defendant in such a case, the effort would be a long slog, since trial courts in nearly half the state's counties are bound to follow those faulty precedents, and in the remaining counties, the fact that there are five reported cases supporting the hospital plaintiff's view of the legal rules will weigh heavily against the defendant. Nonetheless, a well-prepared attorney, one who is familiar with each of the cases discussed in this Article, one who knows in advance that the hospital's counsel is certain to cite them in its arguments, one who knows well why they were wrongly decided and should not be followed, has some hope of ultimately persuading a court that judgment should not be granted to the hospital unless it has carried its burden of proof on the reasonableness of its charges. Only a single reported decision by a court that refuses to adopt the hospitals' unfounded legal arguments would be an encouraging first step toward seeing the law, at last, set right again. Truly fair, adversarial proceedings could become the norm in these disputes once again, instead of a slam-dunk for the hospital every time.

More pragmatically, a defendant represented by counsel armed with the analysis in the preceding pages has an increased probability of winning a voluntary dismissal from the hospital plaintiff, once its counsel is put on notice that any effort to obtain a judgment carries enormous risk beyond the case at hand. No matter the size of the medical bill, an astute plaintiff, once it realizes its patient is represented by an attorney who understands the content of this Article, will be especially willing to negotiate a settlement for a small fraction of the amount demanded in its lawsuit. So instrumental are those poorly-reasoned decisions in simplifying the hospitals' litigation strategy that the threat of seeing them vanish will ring up as a cost too steep to bear. And, until they are all overruled, getting these defendants represented by counsel becomes all the more important.

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[98] "[T]he doctrine of *stare decisis* is of fundamental importance to the rule of law." Wampler v. Higgins, 93 Ohio St.3d 111, 120 (2001). "However, as a matter of practice a court of appeals, or any panel of judges sitting therein, is not unalterably bound to follow the precedent of a rule previously announced or followed by such court." State v. George, 50 Ohio App. 2d 297, 309-310 (10th Dist. 1975). "[A]n appellate court 'not only has the right, but is entrusted with the duty to examine its former decisions and, when reconciliation is impossible, to discard its former errors.'" Bouher v. Aramark Servs., Inc., 181 Ohio App.3d 599, 2009-Ohio-1597, 910 N.E.2d 40, ¶ 24 (1st Dist.) (quoting Westfield Ins. Co. v. Galatis, 100 Ohio St.3d 216, 2003-Ohio-5849, 797 N.E.2d 1256, ¶ 43-44).