PROPOSED REVISIONS TO THE RULES OF EVIDENCE
PROPOSAL 2026-022

March 6, 2026

The Rules of Evidence Committee has recommended amendments to Rule 11-901 NMRA for the Supreme Court's consideration.

If you would like to comment on the proposed amendments set forth below before the Court takes final action, you may do so by either submitting a comment electronically through the Supreme Court's website at https://supremecourt.nmcourts.gov/rules-forms-files/rules-forms/open-for-comment/ or sending your written comments by mail, email, or fax to:

Elizabeth A. Garcia, Chief Clerk of Court
New Mexico Supreme Court
P.O. Box 848
Santa Fe, New Mexico 87504-0848
rules.supremecourt@nmcourts.gov
505-827-4837 (fax)

Your comments must be received by the Clerk on or before April 5, 2026, to be considered by the Court. Please note that any submitted comments may be posted on the Supreme Court's website for public viewing.

11-901. Requirement of authentication or identification.

A. **In general.** To satisfy the requirement of authenticating or identifying an item of evidence, the proponent must produce evidence sufficient to support a finding that the item is what the proponent claims it is.

B. **Examples.** The following are examples only – not a complete list – of evidence that satisfies the requirement:

(1) **Testimony of a witness with knowledge.** Testimony that an item is what it is claimed to be.

(2) **Nonexpert opinion about handwriting.** A nonexpert's opinion that handwriting is genuine, based on a familiarity with it that was not acquired for the current litigation.

(3) **Comparison by an expert witness or the trier of fact.** A comparison with an authenticated specimen by an expert witness or the trier of fact.

(4) **Distinctive characteristics and the like.** The appearance, contents, substance, internal patterns, or other distinctive characteristics of the item, taken together with all the circumstances.

(5) **Opinion about a voice.** An opinion identifying a person's voice – whether heard firsthand or through mechanical or electronic transmission or recording – based on hearing the voice at any time under circumstances that connect it with the alleged speaker.

(6) **Evidence about a telephone conversation.** For a telephone conversation, evidence that a call was made to the number assigned at the time to:

(a) a particular person, if circumstances, including self-identification, show that the person answering was the one called, or

(b) a particular business, if the call was made to a business and the call related to business reasonably transacted over the telephone.

(7) **Evidence about public records.** Evidence that

(a) a document was recorded or filed in a public office as authorized by law, or

(b) a purported public record or statement is from the office where items of this kind are kept.

(8) **Evidence about ancient documents or data compilations.** For a document or data compilation, evidence that it

(a) is in a condition that creates no suspicion about its authenticity,

(b) was in a place where, if authentic, it would likely be, and

(c) is at least twenty (20) years old when offered.

(9) **Evidence about a process or system.** Evidence describing a process or system and showing that it produces an accurate result.

(10) **Methods provided by a statute or rule.** Any method of authentication or identification allowed by a statute or a rule prescribed by the Supreme Court.

C. **Authenticity and reasonableness of medical bills; necessity of medical services rendered; presumption.**

(1) For the purposes of this rule, "Medical Bill" means any statement of charges, an invoice, or any other form prepared by a health care provider or its agent, or third-party agent, identifying the amounts charged for health care goods and services provided to a person.

(2) In any civil action, the authenticity of a Medical Bill, and the reasonable and customary nature of the amounts charged, shall be rebuttably presumed upon identification by the plaintiff of the original Medical Bill, or a copy of the original Medical Bill. The presumption herein shall not apply unless the opposing party has been provided such Medical Bill at least thirty (30) days prior to the trial.

(3) In any civil action, the necessity of health care goods and services provided to a person shall be rebuttably presumed upon testimony:

(a) identifying the health care provider who provided the health care goods and services, and

(b) describing the health care goods and services rendered.

[As amended by Supreme Court Order No. 12-8300-015, effective for all cases pending or filed on or after June 16, 2012; amended by Supreme Court Order No. _____, effective for all cases pending or filed on or after _____.]

Committee commentary. — The language of Rule 11-901 NMRA was amended in 2012 to be consistent with the restyling of the Federal Rules of Evidence, effective December 1, 2011, to make them more easily understood and to make style and terminology consistent throughout the rules. These changes are intended to be stylistic only. There is no intent to change any result in any ruling on admissibility.

[As amended by Supreme Court Order No. 12-8300-015, effective for all cases pending or filed on or after June 16, 2012.]

New Mexico Courts

Alyssa Segura <supams@nmcourts.gov>

[rules.supremecourt-grp] Open for Comment Form submitted on Supreme Court

Supreme Court <noreply@nmcourts.gov> Fri, Mar 6, 2026 at 12:29 PM
Reply-To: noreply@nmcourts.gov
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Name	Barry
	Green
Phone Number	505/989-1834
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Proposal Number	2026-022
Comment	Parties utilize superior economic power to discourage less affluent litigants. Lately, i have experienced this when asking opposing counsel to stipulate to the authenticity of medical bills and records and they have refused. The process of authenticating medical bills and records then become costly and further delays justice. The proposed changes help eliminate those issues and will serve the interests of judicial economy. Accordingly, I urge the Supreme Court to adopt the proposed Rule changes.

New Mexico Courts

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[rules.supremecourt-grp] Open for Comment Form submitted on Supreme Court

Supreme Court <noreply@nmcourts.gov> Fri, Mar 6, 2026 at 3:34 PM
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Name	Max Jones
	Jones
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Proposal Number	2026-022
Comment	Needing an expert to testify to reasonable, necessary, and causally related medical billing as determined by Segura v. K-Mart Corp., 2003-NMCA-013, ¶ 26, 133 N.M. 192 should be a requirement. In practice, medical billing is not always reasonable, necessary, and causally related and the Court must keep the requirement that an expert is required to provide such testimony. Changing this rule will increase costs of litigation and insurance if all medical billing is to be believed.

New Mexico Courts

Kateri Eisenberg <supkhe@nmcourts.gov>

[rules.supremecourt-grp] Open for Comment Form submitted on Supreme Court

1 message

Supreme Court <noreply@nmcourts.gov> Mon, Mar 9, 2026 at 4:23 PM
Reply-To: noreply@nmcourts.gov
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Name	Justin
	Rodriguez
Phone Number	5055039401
Email	jrodriguez@abrfirm.com
Proposal Number	Proposal 2026-022
Comment	Plaintiff bears the burden of proof on all issues of liability and damages. Proposal 2026-022 shifts the burden on medical damages to Defendants and establishes Plaintiff's alleged damages without proof of same. The rule improperly favors Plaintiffs and shifts the burden of proof on medical damages. As an example, a rule that medical expenses are deemed unreasonable and unnecessary would likewise be improper. The Court should not burden shift using rules and instead require all evidence of reasonableness and necessity established at the time of trial in accordance with the Plaintiff's ordinary burden of proof.

New Mexico Courts

Kateri Eisenberg <supkhe@nmcourts.gov>

[rules.supremecourt-grp] Open for Comment Form submitted on Supreme Court

1 message

Supreme Court <noreply@nmcourts.gov> Fri, Mar 13, 2026 at 12:41 PM
Reply-To: noreply@nmcourts.gov
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Name	Sean
	FitzPatrick
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Email	sfitzpatrick@fitzpatricklawllc.com
Proposal Number	2026-022 Medical Billing
Comment	The rules are finally catching up with reality. In Scott v. Transwestern Tankers. Inc., the New Mexico Supreme Court considered an argument regarding how a plaintiff can prove the reasonableness of a medical bill for which recovery is sought. Scott v. Transwestern Tankers, Inc., 1963-NMSC-205, ¶8, 73 N.M. 219, 387 P. 2d 327. The defense argued that the plaintiff did not offer “proof of the reasonableness of the medical services” reflected in a medial bill presented at trial. Id. And while Transwestern is a workers compensation case, the New Mexico Supreme court stated “[w]hile there is respectable authority to the effect that the burden is on a claimant to show the reasonableness of the services of a doctor,… we note even in personal injury actions in some jurisdictions proof of a bill from a doctor for services rendered is considered sufficient as prima facie proof of reasonableness.” Id ¶8. The rebuttable presumption is a good compromise. If someone thinks they are not reasonable or necessary then they can certainly put on evidence to dispute them. Bravo New Mexico and its hard working committees for decreasing unnecessary litigation.

New Mexico Courts

Alyssa Segura <supams@nmcourts.gov>

[rules.supremecourt-grp] Proposed Rule 2026-022

1 message

nancy@nancycroninlaw.com <nancy@nancycroninlaw.com> Mon, Mar 30, 2026 at 11:51 AM
Reply-To: nancy@nancycroninlaw.com
To: rules.supremecourt@nmcourts.gov

Dear Supreme Court Justice Thompson and Justices:

I write in FAVOR of Proposed Rule 2026-022 for medical bills. I have been a litigator since 1994 and have listed medical bill custodians as witnesses in every action wherein medical treatment was an issue, (except in workers compensation cases or social security disability claims.) The medical bill custodians have never been deposed by opposing counsel and I have never put a medical bill custodian on the stand because opposing counsel has agreed to allow the bills into evidence. This presumption makes sense and will alleviate time and expense in getting Affidavits. It will also help in trial preparation in not sending out 5-15 subpoenas ($$$) to testify as you need to ensure the evidence get it, only to be told close to trial that the other side will not object.

Thank you for your kind consideration.

Nancy Cronin

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New Mexico Courts

Alyssa Segura <supams@nmcourts.gov>

[rules.supremecourt-grp] Proposal 2026-022

1 message

Ryan T. Sanders <rtsanders@btblaw.com> Fri, Apr 3, 2026 at 9:52 AM
Reply-To: rtsanders@btblaw.com
To: "rules.supremecourt@nmcourts.gov" <rules.supremecourt@nmcourts.gov>

I write in opposition to the proposed change to Rule 11-901(C). The proposed changes do not reflect the reality of the variability of medical charges, variability that arises from multiple factors, including why the medical charges were incurred and who is ultimately paying the medical charges. I attach for your consideration an amici brief filed in a matter pending before the Utah Supreme Court, in which the amici cite to a multitude of law review articles highlighting the fact that medical charges do not reflect the reasonable value of medical care. Additionally, the proposed changes do not reflect the reality in tort litigation that necessity of medical care can be reasonably disputed. I draw your attention to the attached complaint filed by the State of California and a number of insurers against a group of medical providers who performed unnecessary diagnostic procedures and produced unsupported reports to support plaintiffs' lawsuits.

In short, the proposed rule change does not promote justice in New Mexico, and I respectfully request the rule change be rejected.

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MEMBER
ALFA International
THE GLOBAL LEGAL NETWORK

2 attachments

24.08.23.Utah-Supreme-Court-Phantom-Damages-Amicus-Brief-Gardner-v-Norman-FINAL.pdf#_~_text=“Chargemaster” rates for medical treatments as well,value of care provided to that plaintiff..pdf
213K

First Amended Complaint for violation of the California insurance fraud act.pdf
459K

IN THE UTAH SUPREME COURT

TROY GARDNER, Plaintiff/Appellee, vs. TYLER NORMAN, Defendant/Appellant.	Appeal No. 2024-03440SC

BRIEF OF *AMICI CURIAE* NATIONAL FEDERATION OF INDEPENDENT BUSINESS SMALL BUSINESS LEGAL CENTER, INC., NATIONAL ASSOCIATION OF MANUFACTURERS, AMERICAN TORT REFORM ASSOCIATION, COALITION FOR LITIGATION JUSTICE, INC., AMERICAN PROPERTY CASUALTY INSURANCE ASSOCIATION, NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES, AMERICAN TRUCKING ASSOCIATIONS, INC., AND UTAH TRUCKING ASSOCIATION IN SUPPORT OF DEFENDANT/APPELLANT AND REVERSAL

On Appeal from the Third Judicial District Court
In and For Salt Lake County, State of Utah
Honorable Keith Kelly, Trial Court Civil No. 220906066

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IDENTITY AND INTEREST OF *AMICI CURIAE*

Amici are organizations whose missions support advancing a balanced civil justice system. Their members include businesses of all sizes, manufacturers, trucking companies, and insurers. *Amici* have a substantial interest in ensuring that awards for medical care reflect the reasonable value of such services. *Amici*'s members are adversely impacted by the district court's approach to valuing special damages, which presents a factfinder with list prices for medical services that a plaintiff's healthcare provider did not receive, while excluding amounts actually accepted by the healthcare provider as full payment for its services. This approach results in inflated medical damage awards that reflect medical billing and negotiation practices rather than their reasonable market rates.

Amici submitting this brief are:

- The National Federation of Independent Business Small Business Legal Center, Inc., a nonprofit, public interest law firm established to provide legal resources and be the voice for small businesses in the nation's courts;
- The National Association of Manufacturers, the largest manufacturing association in the United States;
- The American Tort Reform Association, a nationwide civil justice reform coalition;

- The Coalition for Litigation Justice, a nonprofit association formed by insurers to address the litigation environment for toxic-tort claims;[1]

- The American Property Casualty Insurance Association, the leading national trade association for home, auto, and business insurers, with a legacy dating back 150 years. APCIA members represent all sizes, structures, and regions—protecting families, communities, and businesses in the U.S. and across the globe;

- The National Association of Mutual Insurance Companies, which serves the interests of local and regional mutual insurance companies on main streets across America as well as many of the country's largest national insurers;

- The American Trucking Associations, Inc., the national association of the trucking industry, which, in conjunction with 50 state affiliated trucking organizations, represents over 30,000 motor carriers of every size, type, and class of operation; and

- The Utah Trucking Association, Inc., the state trucking association in Utah dedicated to ensuring that laws, rules, and regulations are written and enforced in a manner that will enhance safety, improve efficiency for Utah truck drivers and Utah trucking companies and minimize negative impacts to business and to the people of Utah that are served by the trucking industry.

NOTICE, CONSENT, AUTHORSHIP, AND FUNDING

Amici provided timely notice to counsel of record for all parties to the appeal of their intent to file this brief.[2] All parties consented to its filing.

[1] The Coalition includes Century Indemnity Company; Allianz Reinsurance America, Inc.; Great American Insurance Company; Nationwide Indemnity Company; Resolute Management, Inc., a third-party administrator for numerous insurers; and TIG Insurance Company.

[2] Counsel for *amici* provided timely notice of their intent to file of an *amicus* brief in support of Defendant, although the signatories to the brief have changed to include the above organizations.

No party or party's counsel authored this brief in whole or in part or contributed money to fund preparing or submitting the brief. No person or entity—other than *amici curiae*, their members, or their counsel—contributed money to fund preparing or submitting this brief.

INTRODUCTION AND SUMMARY OF ARGUMENT

This case presents a straightforward question: Can a plaintiff recover damages for medical expenses based on list prices not actually paid to a plaintiff's healthcare providers, or should a plaintiff instead recover damages based on amounts actually paid and accepted for such services?

Here, the Plaintiff, who was involved in a minor automobile accident with a Salt Lake City police officer, sought $7,267.77 for an emergency room visit, CT scan, and eye examination based on "chargemaster" list prices for services, when his healthcare providers accepted $4,487.75 as full payment. The difference between the two amounts, $2,780.02, constitutes "phantom damages." These "damages" do not reflect an injury to the Plaintiff caused by the Defendant. They were never incurred and simply do not exist.

Plaintiffs may recover the reasonable value of medical care necessary to treat an injury caused by a tortfeasor. Chargemaster rates and other list prices, however, generally do not reflect the reasonable market value of medical services. These rates are often merely the starting point for negotiation between healthcare providers and payors. Providers rarely receive

these full "sticker prices." Rather, list prices for healthcare services often far exceed amounts providers routinely accept as full payment.

The collateral source rule does not require courts to treat these list prices as conclusively establishing the reasonable value of medical services. That rule exists so that a tortfeasor's liability is not reduced when the injured person's costs will be covered by third parties. The rule allows "double recovery" in the limited sense that a plaintiff can recover from both the tortfeasor and an insurer for the same injury. It does not offer "double recovery" in the sense that a plaintiff is entitled to an award based on a list price for treatment that is double (or more) its actual value. That is just an inflated award that miscalculates the amount of damages caused by a defendant and experienced by a plaintiff.

The difference between list prices and amounts paid is not a benefit that a plaintiff secures through obtaining insurance. It reflects the complexities of the modern medical-pricing and billing system. The reasonable value of medical care, as with other products and services, is established through the market. That value—the amount that a willing buyer and seller agree to in a voluntary exchange—is the amount paid and accepted for the medical care, regardless of who pays for it.

This Court should not endorse a misinterpretation of the collateral source rule that (1) requires admitting evidence of list prices that mislead and

confuse the factfinder by presenting an amount that a plaintiff's providers did not receive as the value of care; (2) excludes the best evidence of the reasonable value of medical care, which is the total amount actually paid (from whatever source) and accepted by a plaintiff's providers as full payment; and (3) will lead to vastly inflated awards, both for medical expenses and, indirectly, for general damages. The Court should, instead, follow the growing number of states that ensure that tort law reflects reality and hold that the amount actually paid to a plaintiff's healthcare providers is admissible evidence of the reasonable value of medical care.

ARGUMENT

I. CHARGEMASTER RATES AND OTHER LIST PRICES SET BY HEALTHCARE PROVIDERS, BUT RARELY PAID AND NOT ACTUALLY RECEIVED BY THE PLAINTIFF'S PROVIDERS, DO NOT REFLECT THE REASONABLE VALUE OF MEDICAL CARE

"Chargemaster" rates for medical treatments as well as other list prices that may appear on a healthcare provider's invoice, but are rarely paid and not actually received by a plaintiff's providers, do not reflect the reasonable value of care provided to that plaintiff. The Court should not permit introduction or recovery of list prices that were not paid, because these figures mislead the factfinder and result in inflated damage awards.

As background, it is common practice for healthcare providers to set a fee for each service or treatment, typically represented by a Current

Procedural Terminology (CPT) code.[3] CPT codes are uniform and set by a panel of the American Medical Association, but the amount healthcare providers charge for these services are not. Each healthcare provider is free to set its own fee for each CPT code. Healthcare providers use a similar system to set list prices for various medical products, supplies, and services not included in CPT codes.[4] The healthcare provider records its list prices in its billing system or "chargemaster" and that "standard charge" or "gross rate" is often indicated on the provider's invoice, as it was here.

Chargemaster rates or other list prices for healthcare services often serve as an opening offer or bid, like an MSRP for a new car. Patients and insurers (whether private or governmental) rarely pay these "sticker prices."[5] The market sets the reasonable value of a product or service, not its sticker price or a seller's opening bid. By definition, the fair market value of a service is the amount at which a willing buyer and seller agree, in an arm's length transaction, to pay for and provide that service.[6]

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[3] *See* Am. Med. Ass'n, The CPT® Code Process (2024).

[4] *See* Centers for Medicare & Medicaid Services, HCPCS Level II Coding Procedures (explaining use of the Healthcare Common Procedure Coding System (HCPCS)).

[5] *See Haygood v. De Escabedo*, 356 S.W.3d 390, 393 (Tex. 2011) (observing that healthcare provider "list" rates reflect negotiations with government programs and private insurers and are rarely collected).

[6] *See, e.g.*, Utah Code § 59-2-102(13)(a) (defining "fair market value," for taxation purposes, as "the amount at which property would change hands

Chargemaster or other list prices for medical services do not reflect an agreed amount between a buyer and seller. Indeed, there is often a stark difference between a healthcare provider's list price for a particular service or procedure and the amount it customarily accepts as full payment, whether paid by a private insurer, a government program, or directly by a patient. Chargemaster rates are often many multiples the amount providers routinely accept.[7] Rather, healthcare providers typically receive payment based on negotiated rates with managed care plans or schedules set by Medicare rules.[8] Likewise, uninsured patients rarely pay list prices, as healthcare providers offer programs providing subsidies or discounts to low-income patients and write off an increasing amount of bills that reflect list prices.[9] Hospital

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between a willing buyer and a willing seller, neither being under any compulsion to buy or sell and both having reasonable knowledge of the relevant facts.").

[7] *See, e.g.*, Ge Bai & Gerard F. Anderson, *U.S. Hospitals Are Still Using Chargemaster Markups to Maximize Revenues*, 35(9) Health Affairs 1658, 1662 (2016); George A. Nation III, *Hospital Chargemaster Insanity: Heeling the Healers*, 43 Pepp. L. Rev. 745, 748 (2016).

[8] *See Daughters of Charity Health Servs. of Waco v. Linnstaedter*, 226 S.W.3d 409, 410 (Tex. 2007) ("Few patients today ever pay a hospital's full charges, due to the prevalence of Medicare, Medicaid, HMOs, and private insurers who pay discounted rates."); *see also* Centers for Medicare & Medicaid Services, *Fee Schedule - General Information*.

[9] One study found that patients at California hospitals with private insurance paid 41% of list prices, patients with Medicare and Medicaid paid 35% and 30% of list prices, respectively, and uninsured patients paid 39% of list prices. Glenn A. Melnick & Katya Fonkych, *Hospital Pricing and the Uninsured: Do the Uninsured Pay Higher Prices?*, 27 Health Aff. 116, 118 (2008). The study

representatives caution that "[t]he chargemaster can be confusing because it's highly variable and generally not what a consumer would pay."[10]

The gap between chargemaster rates and amounts typically accepted as payment, the significant variation in pricing among healthcare providers, confusion over hospital bills, and lack of pricing information accessible to consumers were among considerations that led the federal government to adopt price transparency disclosure requirements.[11] These regulations require hospitals to post on their websites their list price ("gross charge") alongside the amounts they have agreed to accept from third-party payors and from uninsured or self-paying patients for each service or procedure.[12] These disclosures confirm that list prices do not necessarily reflect the reasonable value of medical care. Indeed, the evidence in this case indicates that the Plaintiff's healthcare providers did not actually receive the list prices for

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found that, over time, the ratios declined for all payers in part due to the rapid increase in list prices. *See id*.

[10] Sarah Kliff & Dan Keating, *One Hospital Charges $8,000 — Another, $38,000*, Wash. Post, May 8, 2013 (quoting Carol Steinberg, Vice President of the American Hospital Association).

[11] *See generally* Final Rule, Price Transparency Requirements for Hospitals to Make Standard Charges Public,, 84 Fed. Reg. 65,524, 65,525-27, 65,538 (Nov. 27, 2019) (codified at 45 C.F.R. part 180).

[12] *See* 45 C.F.R. § 180.50.

medical treatment that the Plaintiff sought to recover through the civil justice system.[13]

Yet, plaintiffs' attorneys here and in other Utah cases seek to present to judges and juries confusing and misleading chargemaster rates that do not reflect the reasonable value actually received for the medical services provided to plaintiffs. They contend that a tortfeasor should not "benefit" from "negotiated rates" between a healthcare provider and insurer. But it is this very negotiation and the resulting amount paid that establishes the most reliable market-based measure of the reasonable value of medical care. Courts and juries deciding tort claims should not be blindfolded from this reality.

II. AWARDING PHANTOM DAMAGES DOES NOT SERVE THE COMPENSATORY PURPOSE OF TORT LAW OR ADVANCE THE GOALS OF THE COLLATERAL SOURCE RULE

"[T]he basic purpose of tort law is to place an injured person in a position as nearly as possible to the position he would have occupied but for the defendant's tortious behavior."[14] As this case demonstrates, however, some courts permit plaintiffs to receive amounts of medical expenses that exceed actual damages, and are often are multiples of what the plaintiff or the

[13] *See* Appellant's Br. at 23–24.

[14] *Scott v. Universal Sales, Inc.*, 2015 UT 64, ¶ 48, 356 P.3d 1172 (quoting *Kilpatrick v. Wiley, Rein & Fielding*, 2001 UT 107, ¶ 97, 37 P.3d 1130 (internal quotation marks omitted)).

plaintiff's insurer routinely pays for medical care. This overpayment—the difference between the "chargemaster" list price for medical services or the amount initially billed by a healthcare provider, and the amount that the plaintiff's healthcare provider accepted as full payment for those services—is sometimes referred to as "phantom damages." Phantom damages are simply not "damages" at all. Neither the plaintiff nor the tortfeasor's insurer will ever be called upon to pay that amount. Nor will the plaintiff's healthcare provider receive payment at that level.

Injured plaintiffs may recover their medical expenses, provided that they establish that these expenses are both reasonable and necessary to address the harm caused by the tortfeasor.[15] It is the plaintiffs' responsibility to present evidence "to show that the medical expenses accurately reflect the necessary treatment that resulted from the injuries and that the charges are reasonable."[16] The question is whether chargemaster or other list prices set solely by a healthcare provider, primarily as a starting point for negotiation with insurers and other payors, conclusively establish the reasonable value of the plaintiff's medical care, even though the plaintiff's providers accepted less as full payment for that care. As discussed earlier, these prices generally do

[15] *See Gorostieta v. Parkinson*, 2000 UT 99, ¶ 35, 17 P.3d 1110.

[16] *Id.*

not reflect market value, particularly when the plaintiff's healthcare providers accepted a lower amount as full payment. In such instances, the amount actually paid by the plaintiff or third party for the plaintiff's medical care and accepted by the healthcare provider should establish the market-based reasonable value of the service. Chargemaster rates above amounts actually paid to a patient's healthcare providers do not reflect the reasonable value of medical care and are instead merely a starting bid that providers know will be significantly reduced in nearly all instances.

Here, however, Plaintiff argues, and the district court ruled, that the collateral source rule prohibits basic application of market principles in determining the reasonable value of medical care. The collateral source rule does no such thing. It provides that "a wrongdoer is not entitled to have damages, for which he is liable, reduced by proof that the plaintiff has received or will receive compensation or indemnity for the loss from an independent collateral source."[17] "[T]he usual role of the collateral source rule is to prevent insurance payments of damages from reducing the wrongdoer's liability."[18] The usual role of the collateral source rule is not, and should not be, to authorize inflated awards for medical expenses.

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[17] *Gibbs M. Smith, Inc. v. U.S. Fid. & Guar. Co.*, 949 P.2d 337, 345 (Utah 1997) (quoting *DuBois v. Nye*, 584 P.2d 823, 825 (Utah 1978)).

[18] *Id.*

This Court has indicated that "public policy favors giving the plaintiff a double recovery rather than allowing a wrongdoer to enjoy reduced liability simply because the plaintiff received compensation from an independent source."[19] But this public policy basis for the collateral source rule is not advanced by calculating damages for medical expenses based on list prices that a plaintiff's healthcare providers did not receive. Indeed, calculating damages based on the reasonable value of medical expenses has nothing to do with the collateral source rule, which only concerns reimbursement from an independent source. Determining damages based on the actual amount paid and accepted continues to allow for "double recovery" in the limited sense of the common-law rule—the plaintiff can recover those damages even if they were covered and fully paid by an insurer. What a plaintiff cannot do is receive "double recovery" in the sense of inflating the measure of his or her actual damages by double or more based on a list price that far exceeds what the plaintiff's healthcare providers actually received as payment for that care. Certainly, the Court did not mean "double recovery" in the sense of permitting damages that are inflated to be double their actual worth (or more).

Plaintiff argues, and the district court agreed, that lower rates for medical services negotiated between insurers and healthcare providers

[19] *Wilson v. IHC Hosp., Inc.*, 289 P.3d 369, 381 (Utah 2012) (quoting *Green v. Denver & Rio Grande W. R.R. Co.*, 59 F.3d 1029, 1032 (10th Cir. 1995)).

(whether considered "discounts" or "write offs" from list prices) are a benefit that a patient earned through purchasing insurance and paying premiums. Under this theory, a plaintiff is purportedly entitled to collect the list prices of medical treatments under the collateral source rule. The California Supreme Court has persuasively rebutted this incorrect view. As the court explained:

> Plaintiff … receives the benefits of the health insurance for which she paid premiums: her medical expenses have been paid per the policy, and those payments are not deducted from tort recovery.
>
> Plaintiff's insurance premiums contractually guaranteed payment of her medical expenses at rates negotiated by the insurer with the providers; they did not guarantee payment of much higher rates the insurer never agreed to pay. Indeed, had her insurer not negotiated discounts from medical providers, plaintiff's premiums presumably would have been higher, not lower. In that sense, plaintiff clearly did not pay premiums for the negotiated rate differential. Recovery of the amount the medical provider agreed to accept from the insurer in full payment of her care, but not more, thus ensures plaintiff receives the benefits of her thrift and the tortfeasor does not garner the benefits of his victim's providence.[20]

In sum, the "discount" between the list price and the amount paid is not a collateral benefit, it is the difference between fiction and reality.

The evidentiary purpose of the collateral source rule, avoiding any prejudice from informing a jury that a plaintiff's expenses were covered by insurance, remains intact when juries hear the actual amount paid for the plaintiff's medical services, rather than a list price. This purpose is served

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[20] *Howell v. Hamilton Meats & Provisions, Inc.*, 257 P.3d 1130, 1144 (Cal. 2011) (internal quotations omitted).

when a plaintiff bears no need to indicate, in a case tried to a jury, the source of the payment. But the jury must learn the amount actually accepted by a plaintiff's healthcare providers as payment for their services to the plaintiff, regardless of who paid them. That amount is highly relevant; indeed, it is the best evidence of the reasonable value of the medical services provided to the plaintiff, and thus the measure of that plaintiff's damages. The purposes of the collateral source rule are not advanced by blocking a judge or jury from considering this key information when determining the reasonable value of the plaintiff's medical care. When the factfinder is permitted only to consider list prices for medical treatment that were not paid to the plaintiff's healthcare providers, it does, however, violate the fundamental principle of tort law that a plaintiff is entitled to recover only reasonable charges to be made whole.[21]

Plaintiffs' lawyers seek to present chargemaster list prices for medical expenses, rather than the actual amount paid for the plaintiff's treatment, for other reasons—none of which advance the purposes of the collateral source rule. First, though this case involves a patient whose only medical expenses stemmed from examinations following a minor automobile accident, other cases may involve more extensive medical care, lengthy rehabilitation, or even lifelong future treatment. In such cases, the gap between the higher

[21] *See Gorostieta*, 2000 UT 99, ¶ 35.

chargemaster or other list prices and the actual value of the plaintiff's medical care (the amount a plaintiff's healthcare providers accepted as full payment) can add up to hundreds of thousands of dollars.[22]

Second, introduction of chargemaster or other list prices never received by the plaintiff's healthcare providers may mislead a factfinder to inappropriately inflate other aspects of damages. For instance, juries often consider the amount of the plaintiff's medical expenses when making the inherently subjective and difficult determination of an appropriate amount to award for his or her pain and suffering. Some jurors use a multiple of the medical expenses to compute a pain and suffering award.[23] In this case, the district court's award of $8,000 in general damages rounded up and roughly doubled the Plaintiff's already-inflated special damage award, compounding that error. Noneconomic damage awards should reflect actual harm and not be

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[22] *See, e.g., Lee v. Small,* 829 F. Supp. 2d 728, 742 (W.D. Iowa 2011) (plaintiff introduced evidence and sought recovery of roughly $700,000 in medical invoices when healthcare providers accepted about $300,000 as full payment from private health insurance and Medicare); *Goble v. Frohman*, 901 So.2d 830, 832 (Fla. 2005) (in which a jury awarded $574,554.31 for past medical expenses, reflecting the list prices the plaintiff's providers had billed, rather than the $145,970.76 that they accepted as full payment); *Wal-Mart Stores, Inc. v. Crossgrove*, 276 P.3d 562, 568 (Colo. 2012) (Eid, J., dissenting) (plaintiff sought $242,000 billed for medical services, when providers accepted $40,000 as payment in full).

[23] Neil Vidmar, *Empirical Evidence on the Deep Pockets Hypothesis: Jury Awards for Pain and Suffering in Medical Malpractice Cases*, 43 Duke L.J. 217, 253–54 (1993).

influenced by list prices for treatment that merely reflect medical pricing practices.

Finally, the district court's ruling indicates an additional motivation for plaintiffs to introduce chargemaster or other list prices that their healthcare providers did not receive: The court found that a party who "delays payment until after a lawsuit is filed and judgment is entered . . . should not be entitled to the same discounts available to patients or their insurers who voluntarily agree to pay at the time medical services are rendered."[24] In essence, the district court applied the collateral source rule to boost the plaintiff's damages to account for the time value of money and punish a defendant for exercising its right to have its liability decided at trial.[25]

These considerations do not advance the purposes of the collateral source rule and they are inappropriate considerations when calculating damages. Rather, Utah law addresses these interests through the availability of pre-judgment interest in appropriate circumstances. In fact, Utah law specifically provides that if a defendant rejects a reasonable settlement offer, opts to go to

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[24] Order Denying Defendants' Motion in Limine to Exclude All Evidence of Chargemaster Rates for the Medical Services Plaintiff Received at 2 (Nov. 7, 2023).

[25] *See id.* ("Such a later paying party should not have the benefit of discounts that result from pre-service contracts such as PPO agreements or self-pay arrangements negotiated from providers.").

trial, and is found liable, it must pay prejudgment interest on the plaintiff's medical expenses.[26] The interest rate is indexed to market rates and begins to accrue on the first date in which the medical expenses were incurred.[27] In cases involving serious injuries, prejudgment interest can be substantial.[28] This statute assures that the time value of money is accounted for in a judgment in appropriate cases. Defendants receive no benefit from rejecting reasonable settlement offers and taking meritorious cases to trial. Distorting the collateral source rule to fulfill this purpose is both inappropriate and unnecessary.

It is wrong to misapply the collateral source rule in a manner that disregards that list prices generally reflect modern medical billing practices and justifies grossly inflated awards that do not reflect the reasonable market value of medical services.[29] When courts distort the collateral source rule to

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[26] Utah Code § 78B-5-824.

[27] *Id.*

[28] *See, e.g., Marland v. Asplundh Tree Expert Co.*, No. 1:14-CV-40, 2017 WL 2599867 (D. Utah June 15, 2017) (adding $111,199.66 in prejudgment interest to past medical expenses of $193,760); *Sprague v. Avalon Care Center-Bountiful 350 South, LLC*, No. 140908104, 2017 WL 7048283 (Utah D. Ct. Dec. 6, 2017) (adding $190,258.56 in prejudgment interest to $481,000 in past special damages).

[29] *See, e.g.*, J. Zackary Balasko, Comment, *A Return to Reasonability: Modifying the Collateral Source Rule in Light of Artificially Inflated Damage Awards*, 72 Wash. & Lee L. Rev. Online 16 (2015); Todd R. Lyle, Comment, *Phantom Damages and the Collateral Source Rule: How Recent Hyperinflation in Medical Costs Disturbs South Carolina's Application of the Collateral Source Rule*, 65 S.C. L. Rev. 853 (2014); Lauren M. Martin, Comment, *Who's*

allow plaintiffs to recover amounts above that which was actually paid and accepted for a plaintiff's medical care, they are "embracing a fiction that either blindfolds or misleads jurors, when the economic damages are readily capable of precise measurement."[30] The Court should interpret tort law principles, including the collateral source rule, in a manner that reflects reality and makes plaintiffs whole.

III. STATES INCREASINGLY PROVIDE THAT PLAINTIFFS MAY ONLY RECOVER AMOUNTS ACTUALLY PAID AND ACCEPTED FOR THEIR MEDICAL TREATMENT, NOT LIST PRICES

As the gap between list prices and the amount healthcare providers typically accept as full payment for their medical services has grown, states are correcting misuse of the collateral source rule to require inflated awards for medical expenses. This Court should follow this trend, which upholds the purpose of the collateral source rule while ensuring that the tort system values medical damages in a manner that reflects economic reality.

As the Defendant explained, states vary in their approaches to valuing medical damages.[31] About one-third preclude or limit the ability of plaintiffs to

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Swallowing the "Bitter Pill"?: Reforming Write-Offs in the State of Washington, 37 Seattle U. L. Rev. 1371 (2014).

[30] Victor E. Schwartz & Christopher E. Appel, *Perspectives on the Future of Tort Damages: The Law Should Reflect Reality*, 74 S.C. L. Rev. 1, 7 (2022).

[31] *See* Appellant's Br. at 21–23.

recover phantom damages,[32] slightly more allow recovery of list prices, and, in the remainder, like Utah, the issue remains undecided, unclear, or subject to inconsistent rulings.[33]

California law, as discussed earlier, exemplifies the approach this Court should follow. In California, a plaintiff may not recover list prices indicated on a healthcare provider's bill that were never paid "for the simple reason that the injured plaintiff did not suffer any economic loss in that amount."[34] Rather, "a personal injury plaintiff may recover *the lesser* of (a) the amount paid or incurred for medical services, and (b) the reasonable value of the services."[35] Where a healthcare provider has accepted less than a listed or billed amount as full payment for the plaintiff's treatment, the amount paid, not the list price,

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[32] States that limit phantom damages generally fall in three categories: (1) those that admit evidence of the amount paid to the plaintiff's healthcare providers and exclude unpaid list prices (complete bar); (2) those that permit introduction of list prices but require the court to subtract unpaid amounts (set-off approach); and (3) those that allow evidence of both the list prices and amounts paid (all-in approach). *Amici's* position is that the first approach best fulfills the compensatory goal of the tort system while the second and third approaches, which are preferable to requiring factfinders to award list prices, are problematic because they mislead the jury and result in inflated awards.

[33] *See* Victor E. Schwartz & Cary Silverman, Truth in Damages; Florida Juries Should Base Personal Injury Awards on Actual Costs of Treatment, Not Inflated Medical Bills 11–12 (Fla. Justice Reform Inst. 2019 (surveying state law as of 2019, since which time additional states have precluded phantom damages).

[34] *Howell*, 257 P.3d at 1133.

[35] *Id.* at 1138 (emphasis in original).

is admissible to prove the plaintiff's damages, though the source of the payment (the insurer) is not.[36] This approach properly balances the goals of fully and fairly compensating the plaintiff, while maintaining the collateral source rule's evidentiary exclusion of independent sources of payment that the plaintiff secured.

Likewise, the Texas Supreme Court has instructed that, although "it has become increasingly difficult to determine what expenses [for medical care] are reasonable" because of the "great disparities" between healthcare providers' list prices and amounts typically accepted as payment, courts must limit admissible evidence to amounts actually paid or legally obligated to be paid for the plaintiff's treatment.[37] Without such a rule, plaintiffs present testimony that list prices are reasonable, even when they far exceed what healthcare providers collect for each plaintiff's care.[38] Any relevance of list prices to measuring the value of a plaintiff's medical care or noneconomic damages is "substantially outweighed by the confusion it is likely to generate" and therefore inadmissible.[39]

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[36] *See id.* at 1146.

[37] *Haygood*, 356 S.W.3d at 393, 398.

[38] *Id.* at 394.

[39] *Id.* at 398.

Multiple state supreme courts have agreed that, rather than advance the purpose of the collateral source rule, "impos[ing] liability for medical expenses that a health care provider is not entitled to charge does not prevent a windfall to a tortfeasor; it creates one for a claimant."[40]

In recent years, five state legislatures have intervened to prevent or correct the type of misapplication of the collateral source rule sought here. Florida, Iowa, Montana, North Carolina, and Oklahoma have each provided that evidence offered to prove the amount of damages for past medical treatment or services is limited to the amount actually paid, regardless of the source of payment.[41] While the Utah legislature can modify or even eliminate the collateral source rule, as it has in the medical liability context,[42] it is firmly

[40] *Id.* at 395; *see also Goble*, 901 So. 2d at 832 ("[F]orcing an insurer to pay for damages that have not been incurred would result in a windfall to the injured party," which would be passed on to the state's residents through higher insurance rates); *Moorhead v. Crozer Chester Med. Ctr.*, 765 A.2d 786, 790 (Pa. 2001), *abrogated on other grounds by Northbrook Life Ins. Co. v. Commonwealth*, 949 A.2d 333 (Pa. 2008) ("Awarding [a plaintiff an amount charged but never incurred] would provide her with a windfall and would violate fundamental tenets of just compensation.").

[41] Fla. Stat. § 768.0427(2) (enacted 2023); Iowa Code §§ 622.4, 668.14A (enacted 2020); Mont. Code Ann § 27-1-308 (enacted 2021); N.C. Gen. Stat. Ann. ch. 8C, Rule 414 (enacted 2011); Okla. Stat. Ann. tit. 12, § 3009.1 (enacted 2011); *see also* Tex. Civ. Prac. & Rem. Code Ann. § 41.0105 (enacted 2003).

[42] Utah Code Ann. § 78B-3-405.

within this Court's purview to interpret and properly apply this common law doctrine.[43]

Allowing plaintiffs to recover list prices that are often multiples of amounts actually accepted by their healthcare providers as full payment will affect everyone who lives and works in Utah. Should the district court's approach become the law of this state, damage awards and settlement demands will be arbitrarily and unnecessarily higher in virtually every personal-injury case—from common slip-and-fall and auto accident claims to product liability actions. Ultimately, these higher costs, based on fiction rather than reality, will be reflected in insurance rates paid by Utah's drivers, homeowners, and businesses. The collateral source rule does not compel this misguided path.

CONCLUSION

For these reasons, the Court should hold that the district court erred in admitting evidence of list prices for the Plaintiff's medical treatment and excluding evidence of amounts the Plaintiff's healthcare providers actually accepted as full payment for his medical care. The Court should vacate the verdict and remand the matter for a new trial on damages.

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[43] *See DuBois*, 584 P.2d at 825 n.1 (citing Utah case law for the origin of the collateral source rule).

Respectfully submitted,

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Dated: August 23, 2024

CERTIFICATE OF COMPLIANCE

Pursuant to Utah R. App. P. 24(a)(11), I certify that this brief complies with the word count limitations of Utah R. App. P. 24(g) because, excluding parts of the document exempted by Rule 24(g)(2), this document contains 5,470 words.

I further certify that this brief complies with the requirement of Utah R. App. P. 21 governing public and private records.

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CERTIFICATE OF SERVICE

I hereby certify that on this 23rd day of August, 2024, a true and correct copy of the foregoing *Amici Curiae* Brief was electronically filed with the Clerk of the Court, which sent notification of such filing to the following:

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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF ORANGE

PEOPLE OF THE STATE OF CALIFORNIA, *ex rel.*, FARMERS INSURANCE EXCHANGE, MID-CENTURY INSURANCE COMPANY, and TRUCK INSURANCE EXCHANGE, Plaintiffs, v. SCOTT AUERBACH; RICHARD P. NEWMAN, M.D.; MEDTRAK DIAGNOSTICS, INC., a Nevada Corporation; INTERPRA, INC., a Nevada Corporation; and DOES ONE through ONE HUNDRED, inclusive. Defendants.	Case No.: 30-2023-01335526-CU-MC-CXC Assigned To Hon. Lon Hurwitz - Dept. CX103 **FIRST AMENDED COMPLAINT FOR VIOLATION OF THE CALIFORNIA INSURANCE FRAUDS PREVENTION ACT; THE CALIFORNIA UNFAIR COMPETITION ACT; DEMAND FOR JURY TRIAL** Complaint Filed: July 5, 2023 Trial Date: None set

Plaintiffs PEOPLE OF THE STATE OF CALIFORNIA, ex rel., FARMERS INSURANCE EXCHANGE, MID-CENTURY INSURANCE COMPANY, and TRUCK INSURANCE EXCHANGE (collectively, "Plaintiffs"), allege as follows:

I. INTRODUCTION

1. This case is about a health care report mill designed and operated by Defendants to fraudulently inflate the reimbursement value of personal injury claims. Defendants prey upon personal injury claimants (hereinafter referred to as "PICs") in order to bilk money from insurance

carriers, including Plaintiffs. The scheme is simple. Defendants conduct videonystamography testing on a PIC without any of the standard clinical and technical precautions, and then generate voluminous health care reports using the purportedly accurate testing data. The heath care reports purportedly contain a clinical assessment and diagnosis of a traumatic brain injury and recommend extensive and expensive future care for the remainder of the PIC's life. These health care reports give the appearance that a Medical Doctor reviews and analyzes all objective and subjective information relating to the PIC, diagnoses the PIC with a traumatic brain injury, and prepares a comprehensive care plan forecasting future medical treatment for the duration of the PIC's life.

2. In reality, the health care reports are generated in seconds by an automated computer system using templated language. Once generated, the reports are rubber stamped using the electronic signature of defendant Richard Newman, a Medical Doctor. Further, the automated computer system itself and the templated language it uses were created and continue to be operated and maintained by a non-physician and not a Medical Doctor. These reports are generated on a massive scale. Defendants generate hundreds of reports per month and have generated thousands of reports over the duration of the scheme. These reports are generated for PICs throughout the United States, including California. However, these reports are not generated to provide care to the PIC, but rather the reports are generated with the intent to be presented to an insurance company or other payor in support of a personal injury claim in order to increase the reimbursement value of that claim.

3. As a result, Defendants have presented numerous health care reports to Plaintiffs in support of claims for payment containing statements that are false, misleading, and characterized by deceit, dishonesty, or trickery. Attached hereto as Exhibit A is a list identifying the claims presented to Plaintiffs by Defendants that have been identified as of the date of the filing of this First Amended Complaint. It is misleading and deceitful to present health care reports that ostensibly represents that a Medical Doctor diagnoses a traumatic brain injury and provides a comprehensive health care plan for the rest of the life of a human being when the health care reports were in fact generated in seconds by a computer. It is misleading and deceitful to provide health care reports that contain templated language that was prepared by a non-physician and

simply rubber stamped with the electronic signature of a Medical Doctor. It is misleading and deceitful to provide health care reports that contain diagnoses of traumatic brain injury that are prepared without any standard clinical and technical precautions. It is misleading and deceitful to provide health care reports that were generated not to provide future care to the PIC but rather to increase the reimbursement value of the personal injury claim and put money in the pockets of non-physicians.

4. Defendants' conduct was and is in direct violation of applicable law including, but not limited to, California Penal Code sections 471.5, 549, and 550; the California Insurance Frauds Prevention Act, codified as California Insurance Code section 1871.7; and the California Unfair Competition Act, codified as California Business and Professions Code section 17200 *et seq*. Accordingly, Plaintiffs bring this action on its own behalf as well as on behalf of the People of the State of California to recover penalties, assessments, and restitution as well as to enjoin, deter and/or prevent Defendants from engaging in such conduct in the future.

II. JURISDICTION AND VENUE

5. The California Insurance Frauds Prevention Act empowers and encourages any interested person, including insurers such as Plaintiffs, to bring a civil action under Insurance Code section 1871.7 against those who submit, or cause to be submitted, false or fraudulent claims against insurers or those who present statements in support of claims that contain any false or misleading information. The California Courts of Appeal have emphasized that the statute has been repeatedly amended specifically to authorize and encourage insurers to bring fraud actions under section 1871.7. In enacting section 1871.7, the California Legislature envisioned that insurance companies, working with law enforcement agencies, could contribute to the effort to combat the prevalent and serious problem of insurance fraud. California law interpreting section 1871.7 has imposed liability on persons who actually file false or fraudulent claims as well as persons other than those who actually file the suspect claim, including medical practitioners who submit false documentation in support of a claim and persons who file a false statement in support of a claim. As such, Insurance Code section 1871.7 provides for a *qui tam* civil action specifically authorizing insurers to prosecute proscribed conduct and bring fraud actions under the section.

6. This is a civil action arising under the laws of the State of California to redress violations of California law including but not limited to the California Insurance Frauds Prevention Act, codified as California Insurance Code section 1871 et seq. and the California Unfair Competition Act, codified as California Business and Professions Code section 17200 et seq. This Court has jurisdiction over the subject matter of this civil claim pursuant to the California Constitution Article VI, Section 10; Insurance Code section 1871.7; as well as California Business and Professions Code section 17200 et seq.

7. Jurisdiction and venue over the person, and corporate entities named in the complaint are proper because Defendants can be found in and/or transact and transacted business in Orange County and the State of California; and while in the County of Orange and the State of California the Defendants engaged in illegal and fraudulent conduct prohibited by Insurance Code section 1871.7 et seq. and Business and Professions Code section 17200 et seq.

8. Plaintiffs' policyholders, other insurance companies and their insureds, the California public, and the State of California were and are the direct victims of the illegal and fraudulent scheme conducted by Defendants.

III. PARTIES

9. Plaintiff Farmers Insurance Exchange is an interinsurance exchange domiciled in the State of California and is authorized to and does transact business within the State of California. Plaintiff Farmers Insurance Exchange brings this action for its own benefit and as a relator on behalf of and for the benefit of the People of the State of California under the provisions of California Insurance Code Section 1871.7, subsection (e)(1).

10. Plaintiff Mid-Century Insurance Company is a property and casualty insurance company domiciled in the State of California and is authorized to and does transact business within these lines of insurance in the State of California. Plaintiff Mid-Century Insurance Company brings this action for its own benefit and as a relator on behalf of and for the benefit of the People of the State of California under the provisions of California Insurance Code Section 1871.7, subsection (e)(1).

11. Plaintiff Truck Insurance Exchange is an interinsurance exchange domiciled in the

State of California and is authorized to and does transact business within the State of California. Plaintiff Truck Insurance Exchange brings this action for its own benefit and as a relator on behalf of and for the benefit of the People of the State of California under the provisions of California Insurance Code Section 1871.7, subsection (e)(1).

12. Defendant Scott Auerbach is a resident of Clark County, Nevada.

13. Defendant Richard P. Newman, M.D. is a resident of Brevard County, Florida.

14. Defendant MedTrak Diagnostics, Inc. is a Nevada Corporation with its principal place of business in the City of Henderson, County of Clark, State of Nevada.

15. Defendant Interpra, Inc. is a Nevada Corporation with its principal place of business in the City of Henderson, County of Clark, State of Nevada.

16. The true names or capacities, whether individual, corporate, associate, or otherwise, of Defendants sued herein as DOES ONE through ONE HUNDRED, inclusive, are unknown to Plaintiffs, who therefore sue such defendants by such fictitious names. Plaintiffs are informed and believe and upon such information and belief allege that each of the Defendants designated herein as a DOE were or are individuals or entities that are legally responsible in some manner for the conduct herein alleged.

17. DOES ONE through ONE HUNDRED were or are individuals or entities acting as agents or employees of Defendants, acting within the scope of agency or employment, and engaging in the conduct hereinafter alleged. Each individual or entity acted with full knowledge of the illegality of the activities and conduct undertaken in connection with the aforementioned entities, and conspired in, acquiesced, ratified, or approved of the conduct herein alleged undertaken by the other Defendants.

18. DOES ONE through ONE HUNDRED were or are individuals or entities who aided, abetted, assisted, otherwise participated in, or were or are involved in the fraudulent conduct hereinafter described; and aided, abetted, or assisted the other defendants with full knowledge of the illegality of the activities and conduct.

19. Defendants, and each of them, knowingly, willfully, and intentionally conspired with each other Defendant and agreed to a course of action to defraud Plaintiffs and other similarly

situated insurance companies through illegal schemes as well as fraudulent and/or unlawful claims made against insurance policies, including, but not limited to, automobile liability policies, as herein alleged.

20. Plaintiffs are informed and believe, and thereon allege that, at all times herein relevant, there was a unity of interest between the entity Defendants named herein, including MedTrak Diagnostics, Inc.; Interpra, Inc.; and other DOE Defendants, and the individual Defendants named herein, including Scott Auerbach, Richard P. Newman, and other DOE Defendants, such that any individuality and separateness between these entities and individuals has ceased.

21. The entity Defendants are, therefore, the alter egos of the individual Defendants, and are and were mere shells, instrumentalities, and conduits through which the individuals carried on their business.

22. Adherence to the fiction of the separate existence of the entity Defendants, as distinct from the individual Defendants, would permit an abuse of the corporate privilege, and would promote injustice by protecting the individual Defendants from liability for the wrongful acts committed by them. Any references or allegations regarding or relating to the entity Defendants apply equally to the individual Defendants.

23. Plaintiffs are further informed and believe, and thereon allege, that the individual Defendants have common supervision, control, management, officers, and a unity of interest in ownership in the entity Defendants, which is reflected in the comingling and pooling of earnings, expenses, and losses, such that for all intents and purposes they are one and the same and but the alter ego of one another.

24. The "alternative" alter ego relationship between the entity Defendants and the individual Defendants should be recognized to prevent an injustice. If the alter ego relationship between such Defendants should not be recognized, an inequity would result because an entity responsible for wrongdoing would be shielded from liability.

IV. FACTUAL ALLEGATIONS

25. Defendant Scott Auerbach ("Auerbach") is not a medical doctor. Auerbach is not

a neurologist. Auerbach is not a chiropractor. Auerbach is a physical therapist who maintains an active professional license only in the State of Nevada. Auerbach has no other health care licenses or certifications of any kind. Auerbach has no formal professional training of any kind for the treatment, care, or diagnosis of brain injuries.

26. Auerbach is the sole owner of entity Defendant MedTrak Diagnostics, Inc. ("MedTrak"), which is a corporation that purports to provide medical device equipment and videonystamography testing services that purport to diagnose traumatic brain injuries. MedTrak is a Nevada Corporation and was formed on September 25, 2018. Auerbach serves as the President, Secretary, Treasurer, and sole Director of MedTrak. There are no other corporate officers or directors. MedTrak's registered agent is Auerbach, with an address of 1372 River Spey Avenue, Henderson, Nevada, 89012. MedTrak's main office is located at 400 N. Stephanie Street, Suite 224, Henderson, Nevada, 89014.

27. In addition to its main office in Henderson, Nevada, MedTrak operates out of numerous other locations in many states throughout the United States; including Arizona, California, Colorado, Florida, Hawaii, Kentucky, Louisiana, Nebraska, New Mexico, New York, and Texas. Further, MedTrak and Auerbach employ persons to perform videonystamography testing who travel from the MedTrak headquarters in Henderson, Nevada, to its other locations across the United States, including California.

28. In California, MedTrak operates out of twenty-six (26) different locations, including Berkeley, Campbell, Castro Valley, Chino Hills, Concord, Costa Mesa, El Cajon, Fresno, Glendale, Hemet, La Mesa (2x), Los Angeles, Milpitas, Modesto (2x), Newport Beach, Northridge, Oakland, Palm Springs, Sacramento, San Francisco, Spring Valley, Vallejo, and Walnut Creek(2x). Despite conducting extensive business in the State of California, Plaintiff's investigation, to date, revealed that MedTrak has not filed paperwork with the California Secretary of State. Despite providing extensive medical services in the State of California, Plaintiff's investigation, to date, revealed that MedTrak has not obtained a Fictitious Name Permit with the California Medical Board.

29. Similar to MedTrak, Defendant Interpra, Inc. ("Interpra") is also a Nevada

Corporation and purports to provide services interpreting videonystamography testing data. Interpra was formed on February 18, 2010. Auerbach serves as the President, Secretary, Treasurer, and sole Director of Interpra. There are no other corporate officers or directors. Like MedTrak, Interpra, Inc.'s registered agent is Auerbach, with an address of 1372 River Spey Avenue, Henderson, Nevada, 89012.

30. Defendant Richard P. Newman, M.D. ("Newman") is a neurologist. However, Newman spent his entire career treating strokes and movement disorders and not diagnosing brain injuries. Moreover, Newman has no ownership interest in either MedTrak or Interpra. Instead, Newman is paid by MedTrak as an independent contractor. Newman resides in Florida but provides health care related services for patients in California.

31. Defendants purport to provide videonystamography ("VNG") testing and interpretation for PICs. Defendants claim their testing and interpretation can objectively assess a traumatic brain injury and objectively diagnose the cause of the symptoms of the traumatic brain injury. VNG is a computerized, non-invasive, objective test that measures eye movements using infrared goggles. VNG consists of multiple tests that intend to test the functionality of the vestibular system. VNG can differentiate between peripheral and central disorders. It includes tests to check the oculomotor system and the vestibulo-ocular reflex.[1]

32. Before conducting a VNG, standard clinical precautions must be followed. It is essential to take a detailed history and clinical examination, including otoscopy and ocular movements, followed by a neuro-otological examination. It is important to ask the patient not to have any eye makeup or contact lenses during the test. Patients are also advised to have food at least three hours prior to the test, or else they are prone to develop nausea and vomiting during the tests. Patients should be briefed about the nature of the test being benign, or else erroneous results may occur if the patient is apprehensive/anxious. Drugs like benzodiazepines, anti-depressants, vestibular sedatives, and anxiolytics suppress the caloric test. Neck disorders like ankylosing spondylitis should be ruled out before the test because in such cases, static and dynamic positional tests are contraindicated. Ear examination should be done in all patients to assess the status of the

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9910122/

tympanic membrane and to remove any wax or debris present. Any ptosis, refractory error, or restricted eye movements should be documented, and, in such cases, binocular VNG should be avoided. One must ensure that the patient is off vestibular sedatives for a minimum of 48-72 hours, and once the prerequisites are met, one can proceed with the calibration of the eye for the test.[2]

33. During VNG testing, standard technical precautions must also be followed. The VNG examiner must determine whether the test results accurately reflect the physiologic and pathologic status of the patient whether the test results actually represent artifacts caused by technical errors. To identify technical errors, the examiner must have a basic knowledge of the capabilities and limitations of the VNG equipment. Also, the examiner must be familiar with the underlying physiology of the vestibular function tests. Technical errors must be suspected when results cannot be explained by any known physiology or pathology of the vestibular and oculomotor pathways. The most common errors are as follows: (1) failure to perform physical examination of eye movements, (2) faulty calibrations, (3) failure to maintain a steady level of alertness, and (4) failure to elicit physiologically valid caloric responses.[3] Further, positional testing includes both static and dynamic testing. As in the clinical assessment, during static positional testing, the PIC is required to be placed in multiple positions in darkness.[4]

34. None of these standard clinical or technical precautions are documented or followed by MedTrak. MedTrak technicians have stated that the PIC's responses to pre-testing questionnaires would never prevent MedTrak from performing the testing. PICs have stated that they were not given any instructions regarding any of these clinical precautions prior to the testing. Technicians have stated that none of the equipment is calibrated, as they believe it to be self-calibrating because everything is done through the computer. As such, the required clinical and technical precautions are irrelevant because the computer-generated reports and the conclusions contained in the reports are all identical, without variance. The conclusion is always that the testing is indicative of mild traumatic brain injury. Further, questionnaires contained in records

[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9910122/
[3] https://www.audiologyonline.com/articles/common-errors-in-eng-vng-978
[4] https://www.sciencedirect.com/topics/medicine-and-dentistry/videonystagmography

from MedTrak confirmed that when certain tests are normal, the computer-generated health care reports do not contain any reference to the normal tests.

35. Further, the purported MedTrak testing locations are simply the offices of other health care providers, and not MedTrak dedicated locations. The MedTrak testing is merely performed in the corner of an evaluation room at the offices of other health care providers. No California testing locations even identify the locations as MedTrak offices. Moreover, these "testing rooms" have windows that provide an ambient and an artificial light source, contrary to standard practice.

36. In support of MedTrak's purported assessments and diagnoses, Defendants generate voluminous health care reports on behalf of the PICs, including a Video ENG Report and a Proposed Care Plan. These two (2) reports contain a whole host of statements and representations, including summaries of test results, summaries of subjective complaints from both the PIC and the treating provider, a correlation of the subjective and objective findings, impressions and conclusions regarding traumatic brain injury and the need for ongoing rehabilitation programs, recommendations for specific weekly and daily rehabilitation, recommendations for a long-term care program lasting the rest of the PIC's life, and numerous specific calculations regarding the cost of all of the recommended future care. Indeed, the scope of the statements and representations made by Defendants in these reports is massive.

37. Both the Video ENG Reports and the Proposed Care Plans are electronically signed by both Newman and Auerbach, giving the appearance that a Medical Doctor – Newman – prepared and drafted the massive amount of detailed health care information contained in the reports, including subjective and objective findings, impressions and conclusions regarding traumatic brain injury, and future health care costs that are expected for the remaining years of the PIC's life. In fact, the Proposed Care Plans state explicitly that they were "developed, reviewed and finalized" by Newman. However, in actuality, the Interpra, Inc. software system generates the reports and affixes the signature of both Auerbach and Newman.

38. In truth, the Video ENG Reports and Proposed Care Plans are generated by Auerbach in his office in Henderson, Nevada using the Interpra, Inc. computer software system

that simply inserts templated language into the reports. Newman plays no part in authoring the language contained in the reports. The reports are then purportedly sent to Newman in his Florida office for review and approval. However, Newman has no knowledge of the mechanism for how the reports are generated or how the language contained in the reports is inserted. In fact, it was Auerbach who originally constructed the template for the Proposed Care Plan, and not Newman. Moreover, it was Auerbach who created the automated computer system that generates the reports. Newman, the only medical doctor affiliated with MedTrak or Interpra, Inc., has no understanding of how the automated computer system generates the Video ENG Reports and the Proposed Care Plans.

39. Defendants' automated computer system can generate these Video ENG Reports and Proposed Care Plans in mere seconds. Indeed, a Medical Doctor is not even necessary for generation of the MedTrak reports. Moreover, in the vast majority of cases the only Medical Doctor involved – Newman – does not see the PIC physically or otherwise, does not review the PIC's medical records, does not interview the PIC despite representations in the reports to the contrary and does not examine the PIC. Indeed, on average Newman reviews between three hundred (300) and four hundred (400) reports per month for MedTrak. Assuming Newman is working full time for MedTrak at one hundred thirty (130) hours per month, that would mean Newman is reviewing and interpreting data and preparing a Video ENG Report and Proposed Care Plan for a PIC every twenty (20) to twenty-six (26) minutes of every working day. Similarly, Auerbach has been involved with two hundred fifty thousand (250,000) patients over the last eighteen (18) years. Again, assuming Auerbach is working full time at one hundred thirty (130) hours per month, that would mean Auerbach is reviewing and interpreting data and preparing reports for an injured person every nine (9) minutes of every working day.

40. The purpose of Defendants' Video ENG Reports and Proposed Care Plans is not to provide health care services to the PIC, but rather to increase the reimbursement value of personal injury claims. The reports are generated with the intent to be presented to an insurance company or other payor in support of a claim to be paid under a policy of insurance and to increase the reimbursement value of the claim. Indeed, MedTrak and Auerbach regularly and aggressively

market their services to Plaintiffs' Attorneys all over the country, claiming that their services "create value for personal injury Plaintiffs." In fact, the MedTrak marketing materials specifically state that "the primary advantage to MedTrak Diagnostic's battery of testing…lies in the increased value of the case…"

41. As such, the reports submitted by Defendants to Plaintiffs in connection with claims for payment contain statements that are false, misleading, and characterized by deceit because the reports give the appearance that a Medical Doctor, specifically Newman, reviewed and analyzed all objective and subjective information relating to the PIC and prepared a holistic health care plan for the entire remaining life of the PIC. In actuality the MedTrak reports were generated in seconds by Interpra, Inc.'s automated computer system using templated language and affixing the electronic signature of Newman. It is misleading and deceitful to provide life care plans that ostensibly provide a holistic health care plan for the entire remaining life of a human being that were in fact generated in seconds by a computer. It is misleading and deceitful to provide life care plans that contain templated language that was prepared by a non-physician and simply rubber stamped with the electronic signature of a Medical Doctor.

42. Further, MedTrak conceals from anyone relying on these reports the fact that MedTrak is, in truth, a report mill designed to maximize profits by generating as many reports as quickly as possible for a massive number of PICs across the country. MedTrak, and it sole non-physician owner Auerbach, are being paid $10,000 for each report. Auerbach, as a non-physician who does not have to report to any medical board and as the sole owner of MedTrak, Interpra, Inc., and other business entities, has the profit motive to generate as many reports for as many patients as quickly as possible. The MedTrak business enterprise is enormous, operating in numerous states all over the country and at least twenty-six (26) locations in California alone, including one operating not out of a medical facility but out of a law office in Palm Springs. It is misleading and deceitful to conceal the fact that MedTrak is a company designed to make as much money as possible to put into the pocket of that non-physician owner.

43. The reports submitted to Plaintiffs by MedTrak are also false, misleading, and characterized by deceit because every report submitted to Plaintiffs uniformly states that the PIC

purportedly sustained a "head trauma" allegedly caused by an accidental event. Ostensibly, this is the justification MedTrak uses for conducting the videonystamography testing. However, in many cases the PIC's medical records for care received contemporaneously at the time of the accident, or any time prior to MedTrak's involvement, contain no diagnosis or no evidence that a PIC suffered any acute injury to their head, scalp, skull, or brain, including bleeding, bruising, swelling, fracture, or loss of consciousness. In fact, even in some cases where the PIC's medical records do show evidence of a head injury, the Video ENG Reports and Proposed Care Plans generated by MedTrak are nearly identical to those generated for PICs who have no evidence of any such head injury.

44. Moreover, the Video ENG Reports and Proposed Care Plans generated by MedTrak identify numerous subjective complaints for each PIC, averaging twenty-four (24) subjective complaints per PIC and ranging in number from four (4) to thirty-six (36) per PIC. Yet, despite these numerous and varied subjective complaints, the purported objective testing conclusions for each of these unique PICs are identical. To be clear, every single report submitted by MedTrak to the Plaintiffs containing objective testing conclusions recites the following language:

i. *VNG: Significant central vestibular system dysfunction which is consistent with patients who sustained a mild traumatic brain injury.*

ii. *Posturography: Significant balance and coordination system deficits which are consistent with patients who sustained a mild traumatic brain injury.*

iii. *Fukuda/Romberg Balancing Test (when included): reveal significant balance issues which are consistent with patients who sustained a mild traumatic brain injury.*

iv. *Neurocognitive Test: Abnormalities which are consistent with patients who sustain a mild traumatic brain injury.*

v. *Near Point Convergence (when included): The results of near point of convergence testing reveal oculomotor issues which are consistent with patients who sustain a mild traumatic brain injury.*

vi. *Eye Disconjugacy (when included) The results of eye disconjugacy testing reveal*

oculomotor issues which are consistent with patients who sustain a mild traumatic brain injury.

Moreover, if any of the Fukuda, Romberg, or Eye Disconjugacy test results were in fact normal, the computer-generated reports did not provide any conclusion for those normal tests. Indeed, normal test results were omitted from the report conclusions.

45. The reports submitted to Plaintiffs by MedTrak are also false, misleading, and characterized by deceit because they contain diagnoses of traumatic brain injury that are prepared without any standard clinical and technical precautions. A concussion or traumatic brain injury is an entirely clinical diagnosis defined as an acute change in mental status requiring either a loss of consciousness or a state of confusion. The definition of traumatic brain injury used by the Veterans Health Administration requires loss of or decreased level of consciousness or loss of memory or events immediately before or after the injury. To properly evaluate whether a patient has sustained a traumatic brain injury, the Veterans Health Administration also requires a physical examination targeted to the patient's reported symptoms. Generally, it is accepted medical practice that videonystamography testing is not used in neurology and should not be used as a tool to diagnose a concussion or mild traumatic brain injury.

46. In support of claims for payment submitted to Plaintiffs, the MedTrak reports consistently state that the PIC sustained a traumatic brain injury that will require weekly rehabilitation for the rest of the PIC's life. These representations are based on the videonystamography testing, and not on any physical examination or acute clinical diagnosis made contemporaneously with the injury. Rather, the videonystamography testing is often conducted weeks or months following the injury, and the reports are generated by a computer that affixes Newman's electronic signature to the reports. The methodology used to create the MedTrak reports is not supported by the acceptable medical practices including those set forth by the Veterans Health Administration. Yet, the MedTrak reports are made to give the appearance that they are sound medical opinions and advice when in fact they are not.

47. These false and misleading reports are also accompanied by an itemized bill for MedTrak's services in connection with the Video ENG and Proposed Care Plans reports. These

MedTrak bills are also false, misleading, and characterized by deceit because they uniformly bill for services not rendered or for services that are more expensive than they should be based on the service that was actually performed (a practice known as upcoding). First, MedTrak routinely and systematically bills for the use of a Sinusoidal Vertical Axis Rotational Chair using a CPT Code 92546 when in fact the chairs used by MedTrak are regular office chairs. Image 1 and 2: pictures of an actual Sinusoidal Vertical Axis Rotational Chair:

By contrast, the following are pictures taken on physical clinical inspection of the MedTrak locations in California using a standard office chair with rollers set up with the other MedTrak equipment. Image 3: Chair at Cherik Medical Center, 9535 Reseda Blvd., #109, Northridge, CA 91324.

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Image 4: Chair at OC Pain Specialist, 455 Old Newport Blvd., #101, Newport Beach, CA 92663.

48. Second, MedTrak routinely and systematically bills for providing a bi-thermal caloric test using CPT code 92537. This test requires sequentially irrigating both of a patient's ears with temperate controlled warm and cold water while evaluating the patient's eye movements. The test measures the disturbance in a patient's vestibular system and assesses the function of the nerves involved in hearing. MedTrak does not perform this test. Instead, it either performs no test at all, or a less expensive mono-thermal caloric test (CPT code 92538).

49. Third, MedTrak routinely and systematically bills for providing computerized dynamic posturography (CDP) testing using CPT code 92548. Computerized dynamic posturography testing is a method of quantifying balance and requires the use of an expensive moving platform hardware system that incorporates servomotors into its design. MedTrak does not own or possess the hardware necessary to perform this test. Instead, MedTrak either performs no test at all, or a less expensive Clinical Test of Sensory Integration and Balance (CTSIB) which requires no expensive hardware system.

50. As a result, numerous misleading and deceitful reports and bills have been

generated by Defendants and submitted to Plaintiffs in support of claims for payment under a policy of insurance issued by Plaintiffs. Defendants and their companies knowingly and intentionally engaged in this scheme in connection with many claims which generated massive sums of money. The conduct of the Defendants and other DOE defendants in owning and operating their report mill is fraudulent and undertaken knowing that documents from the scheme would be submitted to insurance companies as support of claims under insurance policies. Defendants, and each of them, conspired, aided, abetted, and assisted each other with full knowledge that the false, fraudulent, misleading, deceitful, and manufactured material would be submitted to an insurance company for payment, and persisted in engaging in such conduct for financial gain, all in violation of California law including Penal Code sections 471.5, 549, 550, and Insurance Code section 1871.7. Defendants have engaged in this insurance fraud scheme with the intent to bilk money out of Plaintiffs and other similarly situated insurance companies and to falsely and fraudulently inflate the value of claims submitted to insurance companies. The fraudulent conduct of Defendants has caused substantial financial losses to Plaintiffs and the People of the State of California.

FIRST CAUSE OF ACTION

(California Insurance Frauds Prevention Act)
(California Insurance Code § 1871.7)

51. Plaintiffs re-alleges and incorporates paragraphs 1 through 48 above as though fully set forth herein.

52. This is a claim for penalties and assessments under the Insurance Frauds Prevention Act, California Insurance Code section 1871.7.

53. By virtue of the conduct alleged herein, defendants, and each of them, have repeatedly violated California Insurance Code section 1871.7, subsection (b), by repeatedly violating California Penal Code sections 549 and 550 by engaging in or aiding, abetting, soliciting, assisting, or conspiring with any person to engage in the following prohibited acts or conduct:

a. Knowingly presenting or causing to be presented false or fraudulent claims for the payment of a loss of injury under a contract of insurance; and/or

b. Knowingly preparing, making, or subscribing writings, with the intent to present or

use them, or allowing them to be presented, in support of a false or fraudulent claim; and/or

c. Knowingly making or causing to be made false or fraudulent claims for payment of a health care benefit; and/or

d. Knowingly submitting claims for a health care benefit that were not used by, or on behalf of, the claimant; and/or

e. Presenting or causing to be presented written or oral statements as part of, or in support of claims for payment or other benefit pursuant to an insurance policy, knowing that the statement contains false or misleading information concerning material facts; and/or

f. Preparing or making any written or oral statements that are intended to be presented to an insurer in connection with, or in support of, claims or benefit pursuant to an insurance policy, knowing that the statements contain false or misleading information concerning material facts; and/or

54. As a result of such conduct on the part of the defendants, Plaintiffs have been damaged in substantial amounts and are entitled to penalties and assessments for each violation in accordance with California Insurance Code section 1871.7, to be determined at trial.

SECOND CAUSE OF ACTION
(California Unfair Competition Act)
(California Business and Professions Code § 17200 *et seq.*)

55. Plaintiffs re-alleges and incorporates paragraphs 1 through 52 above as though fully set forth herein.

56. California Business and Professions Code section 17200 et seq. was enacted by the California State Legislature in 1933 to protect businesses from the unfair business practices of competitors. By the late 1970's the statute was expanded to protect consumers from any "unlawful, unfair or fraudulent business act or practice" and any "unfair, deceptive, untrue or misleading advertising."

57. Under California Business and Professions Code section 17203, "[a]ny person who engages, has engaged, or proposes to engage in unfair competition may be enjoined in any court

of competent jurisdiction. The court may make such orders or judgments, including the appointment of a receiver, as may be necessary to prevent the use or employment by any person of any practice which constitutes unfair competition, as defined in this chapter, or as may be necessary to restore to any person in interest any money or property, real or personal, which may have been acquired by means of such unfair competition."

58. Under California Business and Professions Code section 17201, Plaintiffs are a "person" as defined by the statute.

59. The conduct of Defendants, and each of them, as alleged herein, constitutes "unfair competition" under California Business and Professions Code section 17200, which includes, "any unlawful, unfair or fraudulent business act or practice and unfair, deceptive, untrue or misleading advertising . . . ." Defendants' conduct constitutes unlawful, unfair, and fraudulent business acts in that such conduct violates applicable law including, but not limited to, California Penal Code sections 471.5, 549, and 550; the California Insurance Frauds Prevention Act, codified as California Insurance Code section 1871.7; the California Unfair Competition Act, codified as California Business and Professions Code section 17200 *et seq.*; California Labor Code sections 3820 and 5307.1; California Business and Professions Code section 650; and the Medicare fee schedule.

60. As a result of the conduct of Defendants, and each of them, as alleged herein, Plaintiffs have suffered the loss of substantial amounts of money. Under California Business and Professions Code section 17204, Plaintiffs are a "person who has suffered injury in fact and has lost money or property as a result of such unfair competition." Accordingly, Plaintiffs ask this court to issue orders and enter judgment in favor of Plaintiffs and against Defendants as hereinafter set forth.

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PRAYER

WHEREFORE, Plaintiffs pray for the following relief:

1. For all penalties and assessments allowable under California Insurance Code Section 1871.7(b) as to each Defendant for each instance in which the Defendant is found to have violated California Penal Code sections 549 and 550 for each fraudulent claim presented to Plaintiffs.

2. A temporary injunction to prevent the transfer, concealment, or dissipation of illegal proceeds by Defendants.

3. A temporary injunction to protect the public prohibiting Defendants from engaging in the practice of medicine; prohibiting Defendants from having an ownership interest in any medical practice or corporation; and prohibiting Defendants from further violating California Penal Code sections 549 and 550.

4. A permanent injunction preventing any non-physician Defendant, including a professional medical corporation, from engaging in the practice of medicine.

5. For a permanent injunction prohibiting Defendants from working in, or otherwise being involved with any health-related field, including, but not limited to, physical therapy and neurology.

6. For a permanent injunction prohibiting Defendants from having any ownership interest in any business in a health-related field, including, but not limited to, physical therapy and neurology.

7. For a permanent injunction prohibiting any non-physician Defendant, including a professional medical corporation, from engaging in the practice of medicine.

8. For a permanent injunction prohibiting defendants from violating California Penal Code sections 549 and 550.

9. For a judicial declaration and judgment that any and all bills, billing statements and/or billing invoices generated by Defendants were and are void as a matter of law.

10. For restitution, including, but not limited to, all monies paid by Plaintiffs in

connection with any and all claims made against policies of insurance in which any document generated or produced by Defendants was presented to Plaintiffs in connection with a claim, including, but not limited to, all amounts paid under medical payments provisions, all settlements paid on uninsured motorist claims, all settlements paid on underinsured motorist claims, and all bodily injury settlements;

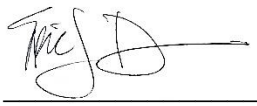
11. For Attorney's fees.

12. For costs of suit; and

13. For such further and other relief as may be deemed appropriate by the Court.

Dated: July 12, 2024

MOKRI VANIS & JONES, LLP



Eric J. Danowitz
Richard A. DiCorrado
Attorneys for Plaintiffs

EXHIBIT A

Claim Number	Treatment Date	Life Care Demand	Billed Amount	Provider Name	Who Submitted Claim
7006432257-1	3/2/24	$2,272,536.00	$10,000.00	Medtrak Diagnostics, Inc.	Law Offices of Karin Wick
7004125810-1	11/20/20	$1,311,408.00	$7,000.00	Medtrak Diagnostics, Inc	Wilshire Law-Carmen Lopez
3012490797-1	11/18/19	$2,192,424.00	$10,000.00	Medtrak Diagnostics, Inc	Law Offices or Arash Khorsandi
7000359250-1	2/11/20	$2,093,616.00	$10,000.00	Medtrak Diagnostics, Inc	Wilshire Law-Bobby Saadian
7001680712-1	3/8/22	$1,987,272.00	$10,000.00	Medtrak Diagnostics, Inc	Albert Abkarian & Assoc.
7000773197-1	2/8/22	$1,480,752.00	$7,000.00	Medtrak Diagnostics, Inc	Farahi Law Firm-Justin Farahi
7002529755-1	8/19/21	$725,760.00	$7,000.00	Medtrak Diagnostics, Inc	Coast Law Group-Brian Felten
7002465492-1	10/4/21	$1,522,854.00	$10,000.00	Medtrak Diagnostics, Inc	Sweet James Accident Attorneys-Bobby Taghavi
5008926870-1	7/2/20	$2,762,928.00	$7,000.00	Medtrak Diagnostics, Inc	Deon Goldschmidt Attorneys
5013723364-1	3/17/22	$1,481,760.00	$7,000	Medtrak Diagnostics, Inc	Banker's Hill Law Firm-Maxwell C. Agha
7002512153-1	5/25/21	$1,917,216.00	$10,000.00	Medtrak Diagnostics, Inc	Omegan Law Group-Robin Saghian
7005390211-1	10/16/23	$2,590,056.00	$10,000.00	Medtrak Diagnostics, Inc	Avrek Law-Melody Parman
7001671202-1	2/24/21	$2,035,656.00	$10,000.00	Medtrak Diagnostics, Inc	MGDesyan Law Firm-George Mgdesyan
3012082720-1	12/19/19	$2,429,784.00	$10,000.00	Medtrak Diagnostics, Inc	Farahi Law Firm-Justin Farahi
7000540554-1	12/28/21	$1,133,496.00	$10,000.00	Medtrak Diagnostics,	Cole Huber

Claim Number	Treatment Date	Life Care Demand	Billed Amount	Provider Name	Who Submitted Claim
				Inc	
3012388981-1	12/11/20	$381,888.00	$7,000.00	Medtrak Diagnostics, Inc	LAW OFFICES OF BENJAMIN ARSENIAN
5008222224-1	12/27/21	$1,954,008.00	$7,000.00	Medtrak Diagnostics, Inc	Stawicki Anderson & Sinclair Attorneys-Nicholas Anderson
7005974331-1	11/6/23	$1,359,288.00	$10,000.00	Medtrak Diagnostics, Inc	William Berg, Injury Lawyers
7003120114-1	12/20/21	$2,817,360.00	$7,000.00	Medtrak Diagnostics, Inc	West Coast Trial Lawyers, Nima Shaahinfar
5008926870-1	7/2/20	$2,762,928.00	$7,000.00	Medtrak Diagnostics, Inc	Deon Goldschmidt Attorneys
3008517539-1	3/9/20	$1,458,600.00	$10,000.00	Medtrak Diagnostics, Inc	ALBERT ABKARIAN & ASSOCIATES
7000787620-1	11/18/21	$1,484,280.00	$10,000.00	Medtrak Diagnostics, Inc	Arash Khorsandi, Law Offices
7002815280-1	7/26/21	$2,807,280.00	$10,000.00	Medtrak Diagnostics, Inc	Martinian & Assoc
7004044846-1	8/23/22	$2,349,648.00	$10,000.00	Medtrak Diagnostics, Inc	Wilshire Law-Shervin Ghanoongooi
7004857691-1	2/17/23	$961,128.00	$10,000.00	Medtrak Diagnostics, Inc	West Coast Trial Lawyers, Aryan Behnamjou
7002704701-1	7/5/22	$2,296,728.00	$10,000.00	Medtrak Diagnostics, Inc	Sasooness Law Group, Samantha Rego
7002485252-1	5/20/21	$2,921,184	$7,000	Medtrak Diagnostics, Inc	Wilshire Law-Andrew Haling
7003438826-1	2/7/22	$1,286,208.00	$7,000.00	Medtrak Diagnostics, Inc	Harker Injury Law-Bronson Harker
7004612525-1	1/23/23	$731,328.00	$7,000.00	Medtrak Diagnostics, Inc	Frontal Law Group-Christompher

Claim Number	Treatment Date	Life Care Demand	Billed Amount	Provider Name	Who Submitted Claim
					Shang
7000336382-1	10/26/21	$2,274,048.00	$10,000.00	Medtrak Diagnostics, Inc	Torem & Assoc. Yigal Torem
7003929011-1	4/8/22	$616,512	$7,000	Medtrak Diagnostics, Inc	Chichyan Law-Morris Chichyan
7003893197-1	8/24/22	$2,849,616.00	$7,000.00	Medtrak Diagnostics, Inc	Wilshire Law Ariella Perry
7003893197-1	8/17/22	$2,301,768.00	$7,000.00	Medtrak Diagnostics, Inc	Wilshire Law Ariella Perry
7004905695-1	12/15/22	$2,732,688.00	$10,000.00	Medtrak Diagnostics, Inc	Law office of Michae Braun-Kevin Haranian
3013518358-1	9/29/20	$1,909,152.00	$10,000.00	Medtrak Diagnostics, Inc	Burg & Brock-Isaac Radnia
5008475085-1	7/22/20	$3,039,120.00	$7,000.00	Medtrak Diagnostics, Inc	Eugene Bruno & Assoc-Andrea Marzner
7002704701-1	7/7/22	$2,296,728.00	$10,000.00	Medtrak Diagnostics, Inc	Sasooness Law Group-Samantha Rego
7005859648-1	4/29/23	$683,280.00	$10,000.00	Medtrak Diagnostics, Inc	Maro Burunsuzyan
7002645814-1	11/24/21	$2,790,144.00	$7,000.00	Medtrak Diagnostics, Inc	Shield Litigation-Paul Nguyen
7002381096-1	5/12/21	$3,239,208.00	$10,000.00	Medtrak Diagnostics, Inc	Burg & Brock-Isaac Radnia
7005893737-1	10/6/23	$3,107,664.00	$10,000.00	Medtrak Diagnostics, Inc	Glendale Law Group-Vilen Khachatryan
7001433678-1	12/29/20	$2,579,472.00	$10,000.00	Medtrak Diagnostics, Inc	Keosian Law-Harout Keosian
7001894483-1	12/16/20	$1,213,632.00	$7,000.00	Medtrak Diagnostics, Inc	Wilshire Law-Ricardo Menard
5010759015-1	7/19/21	$1,510,488.00	$10,000.00	Medtrak Diagnostics, Inc	Law Offices of Stuart Berkley-Stuart Berkley
5010227047-1	2/18/21	$1,734,264.00	$7,000.00	Medtrak	Kane Handel

Claim Number	Treatment Date	Life Care Demand	Billed Amount	Provider Name	Who Submitted Claim
				Diagnostics, Inc	
7004032241-1	7/14/22	$1,710,072.00	$10,000.00	Medtrak Diagnostics, Inc	Solution Now Law Firm-Jimin Oh
5029050307-1	6/16/23	$970,632.00	$7,000.00	Medtrak Diagnostics, Inc	Duran Law Office -Jack Duran
5011935630-1	9/28/21	$2,572,920.00	$10,000.00	Medtrak Diagnostics, Inc	Burg & Brock-Isaac Radnia
5014933948-1	3/22/23	$902,160.00	$7,000.00	Medtrak Diagnostics, Inc	Wilshire Law-Alivia Abreu
7004068791-1	3/15/22	$2,111,760.00	$10,000.00	Medtrak Diagnostics, Inc	Burg & Brock-Isaac Radnia
7001037047-1	4/14/20	$2,853,144.00	$7,000.00	Medtrak Diagnostics, Inc	Law Offices of Tien Cao, Tien Cao
7004137705-1	12/15/23	$1,370,376.00	$10,000.00	Medtrak Diagnostics, Inc	Ilona Gorin
7005094797-1	2/14/23	$1,558,368.00	$10,000.00	Medtrak Diagnostics, Inc	Burg & Brock-Isaac Radnia
7002988010-1	10/11/21	$1,010,016	$10,000	Medtrak Diagnostics, Inc	Eugene Bruno & Assoc-Brian Goh
5015002015-1	4/28/23	$1,565,928.00	$7,000.00	Medtrak Diagnostics, Inc	Linda Tran-attorney
7003475348-1	8/5/22	$2,428,272.00	$10,000.00	Medtrak Diagnostics, Inc	B D & J-Mathew Babdjouni
7004998442-1	12/13/22	$2,572,920.00	$10,000.00	Medtrak Diagnostics, Inc	Megeredchian Law-Ernesio Jimenez
3012109990-1	5/6/20	$1,165,944.00	$10,000.00	Medtrak Diagnostics, Inc	Lalezary Law Firm-Shawn Lalezary
7001879755-1	12/18/20	$1,769,040.00	$7,000.00	Medtrak Diagnostics, Inc	Richard Murphey
7003953271-1	4/26/22	$1,656,192.00	$7,000.00	Medtrak Diagnostics, Inc	Sweet James-Roxy Shekarriz
5009614281-1	11/13/20	$1,734,264	$7,000.00	Medtrak Diagnostics, Inc	Pacific Coast Trial Law Firm-Zhiming Wang

Claim Number	Treatment Date	Life Care Demand	Billed Amount	Provider Name	Who Submitted Claim
7003931084-1	2/22/22	$1,500,408.00	$10,000.00	Medtrak Diagnostics, Inc	Martinian-Tigran Martinian
7004936036-1	9/27/22	$2,463,552.00	$10,000.00	Medtrak Diagnostics, Inc	Burg & Brock-Isaac Radnia
3013397928-1	7/27/20	$1,534,176.00	$10,000.00	Medtrak Diagnostics, Inc	Alpine Law Group-Arin Khodaverdian
7001932028-1	12/8/20	$1,478,736.00	$7,000.00	Medtrak Diagnostics, Inc	Karin Wick, Law offies of Karin Wick
5013685314-1	3/24/21	$2,413,152.00	$10,000.00	Medtrak Diagnostics, Inc	Shirvanian Law Firm-Narbeh Shirvanian
7003101585-1	9/15/21	$972,720.00	$10,000.00	Medtrak Diagnostics, Inc	Albert Abkarian
7006838952-1	2/12/24	$2,768,976.00	$16,000.00	Medtrak Diagnostics, Inc	Lyfe Law-Brisa Andrade
7004656314-1	10/31/22	$995,904.00	$10,000.00	Medtrak Diagnostics, Inc	Chichyan Law-Morris Chichyan-Morris Chichyan
5014383630-1	2/19/22	$1,534,176.00	$10,000.00	Medtrak Diagnostics, Inc	Burg & Brock-Isaac Radnia
7001007589-1	10/21/21	$1,720,656.00	$7,000.00	Medtrak Diagnostics, Inc	M & Y-Daniel Reeves
7002850399-1	9/28/21	$2,020,032.00	$7,000.00	Medtrak Diagnostics, Inc	Adrian Terrado
5013929368-1	11/4/21	$2,075,112.00	$10,000.00	Medtrak Diagnostics, Inc	Hepburn, Hernandez & Jung-Adam Hepburn
7003427551-1	2/4/22	$3,074,904	$10,000	Medtrak Diagnostics, Inc	David Pourati Law Offices-David Pourati
7003539806-1	5/2/22	$1,116,864.00	$10,000.00	Medtrak Diagnostics, Inc	Mesriani Law Group-Rodney Mesriani
5014440905-1	1/14/22	$920,400.00	$7,000.00	Medtrak Diagnostics, Inc	Pacific Coast Trial Law Firm-Zhiming Wang
5015963624-1	4/19/22	$2,411,136.00	$7,000.00	Medtrak	Sweet James-

Claim Number	Treatment Date	Life Care Demand	Billed Amount	Provider Name	Who Submitted Claim
				Diagnostics, Inc	Roxy Shekarriz
3011843567-1	9/14/20	$2,857,176.00	$7,000.00	Medtrak Diagnostics, Inc	Paoli & Purdy, PC
7005160807-1	9/28/21	$2,296,728.00	$10,000.00	Medtrak Diagnostics, Inc	Thomas Murphy
7000664577-1	10/25/22	$3,021,480.00	$10,000.00	Medtrak Diagnostics, Inc.	Scranton Law Office
7002428356-1	12/10/21	$663,264.00	$7,000.00	Medtrak Diagnostics, Inc.	Berg Injury Lawyers-Robert Dalby
7002865823-1	5/25/22	$2,925,216.00	$7,000.00	Medtrak Diagnostics, Inc.	Law Collective-Elliot Eslamboly
7000713249-1	7/21/20	$3,298,680.00	$10,000.00	Medtrak Diagnostics, Inc.	Hillstone Law-Edwin Essakhar
7003646735-1	1/27/22	$2,080,008.00	$10,000.00	Medtrak Diagnostics, Inc.	Oakland Legal Group-Uriel Gdolian
5015002015-1	4/28/23	$1,534,176.00	$7,000.00	Medtrak Diagnostics, Inc.	Linda Tran-attorney
7003238331-1	6/2/22	$1,323,504.00	$10,000.00	Medtrak Diagnostics, Inc.	Compass Law Group-Simon Esfandi
5012318165-1	1/26/22	$959,112.00	$7,000.00	Medtrak Diagnostics, Inc.	Harris Attorneys-Jared Salter
3011534836-1	11/18/19	$2,798,712.00	$10,000.00	Medtrak Diagnostics, Inc.	Patrick Campbell-attorney

PROOF OF SERVICE

SUPERIOR COURT FOR THE STATE OF CALIFORNIA, COUNTY OF ORANGE

CASE NAME: PEOPLE OF THE STATE OF CALIFORNIA VS. AUERBACH

CASE NUMBER: 30-2023-01335526-CU-MC-CXC

I am employed in the County of Orange, State of California. I am over the age of 18 and not a party to the within action; my business address is 4100 Newport Place Drive, Suite 840, Newport Beach, California 92660.

On July 12, 2024, I caused to be served a true and correct copy of the following document(s):

FIRST AMENDED COMPLAINT AND SUMMONS

[X] BY EMAIL SERVICE: Based on a Court order or on an agreement by the parties to accept service by e-mail or electronic transmission, I caused the document(s) described above to be sent from e-mail address **jcabrera@mvjllp.com** to the persons at the e-mail address(es) listed below. I did not receive, within a reasonable time after the transmission, any electronic message or other indication that the transmission was unsuccessful.

Cherie J. Edson
California Department of Insurance
1901 Harrison Street, 6th Floor
Oakland, CA 94612
Cherie.Edson@insurance.ca.gov

Attorneys for Ricardo Lara, California Insurance Commissioner

Stephen Tanizaki
Orange County District Attorney's Office
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Attorneys for Plaintiff- Relators, State Farm Mutual Auto. Insurance Company in Case No. 2024-01373930-CU-MC-CJC

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Attorneys for Defendants, Scott Auerbach, MedTrak Diagnostics, Inc., Interpra, Inc., MedTrak VNG Inc., ScottPT.com, and S&S Health Products, Inc.

///

///

Jeremy M. Friedman
Friedman Law, PC
465 E. Union Street, Suite 201
Pasadena, CA 91101
friedman313@gmail.com

Attorneys for Defendant, Richard P. Newman, M.D.

[X] BY MAIL:

[X] I deposited such envelope in the mail at Newport Beach, California. The envelope was mailed with postage thereon fully prepaid.

[X] As follows: I am "readily familiar" with the firm's practice of collection and processing correspondence for mailing. I placed the above-named document[s] in an envelope, addressed to the party[ies] listed above. Under that practice it would be deposited with U.S. postal service on that same day with postage thereon fully prepaid at Newport Beach, California in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing in affidavit.

[ ] by causing personal delivery of the document(s) listed above to the person(s) set forth on the date indicated below.

MedTrak Diagnostics, Inc.
1372 River Spey Avenue
Henderson, NV 89012

Interpra, Inc.
1372 River Spey Avenue
Henderson, NV 89012

Scott Auerbach
1372 River Spey Avenue
Henderson, NV 89012

Richard P. Newman, M.D.
9110 College Pointe CT
Fort Myers, FL 33919-3244

[X] STATE: I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Executed on July 12, 2024, at Newport Beach, California.

Jasmine Cabrera-Padilla

New Mexico Courts

Kateri Eisenberg <supkhe@nmcourts.gov>

[rules.supremecourt-grp] Open for Comment Form submitted on Supreme Court

Supreme Court <noreply@nmcourts.gov> Fri, Apr 3, 2026 at 8:34 AM
Reply-To: noreply@nmcourts.gov
To: rules.supremecourt@nmcourts.gov

Name	Ben
	Davis
Phone Number	5052327200
Email	bdavis@daviskelin.com
Proposal Number	2026-2022
Comment	The proposed change to 11-901 on medical billing and services is a necessary modernization of our Rules of Evidence. The proposed rule change will reduce the costs of litigation and stop the waste of judicial resources. Currently, an injured party (or even a healthcare provider seeking to recover payment) is required to obtain testimony from a treating provider who is typically not available for trial or hire an expert to provide testimony about the necessity and reasonableness of the treatment already provided. The added expense means that smaller cases will not be prosecuted effectively because of the costs. And it is fair to both sides because if there is a legitimate dispute, then the party disputing the bills has a chance to rebut the presumption. The presumption makes sense from an evidentiary point of view because a medical provider has already acknowledged that these are the charges and that the charges were necessary. Why should we require the provider to come to court and testify about that when the focus should be on the liability and extent of damages, if any. This will streamline trials to avoid very expensive testimony and valuable time of the Court.

New Mexico Courts

Kateri Eisenberg <supkhe@nmcourts.gov>

[rules.supremecourt-grp] Open for Comment Form submitted on Supreme Court

Supreme Court <noreply@nmcourts.gov> Fri, Apr 3, 2026 at 8:52 AM
Reply-To: noreply@nmcourts.gov
To: rules.supremecourt@nmcourts.gov

Name	Samuel
	Walker
Phone Number	5055084640
Email	sam@atkinswalker.com
Proposal Number	2026-022
Comment	I support the rule change. Particularly on the authenticity of medical bills and the amount charged being reasonably. Parties often do not sincerely dispute these issues, and the issue becomes an opportunity for gamesmanship that waste the parties time and judicial resources. If a party presents medical bills and charges, and the opposing party has no evidence to say why they are inauthentic or the amounts charged are unreasonable, then the issue should be moot without further court involvement.

New Mexico Courts

Kateri Eisenberg <supkhe@nmcourts.gov>

[rules.supremecourt-grp] Comments regarding proposed amendments to New Mexico Rule of Evidence 11-901.

Dekleva, Michael <mdekleva@phs.org> Fri, Apr 3, 2026 at 11:27 AM
Reply-To: mdekleva@phs.org
To: "rules.supremecourt@nmcourts.gov" <rules.supremecourt@nmcourts.gov>
Cc: "Brown, Melissa" <mbrown22@phs.org>, "Burt, Ryan" <rburt2@phs.org>, "Collier, Travis" <TCOLLIER2@phs.org>

Good morning,

Attached please find Presbyterian Healthcare Services' comments regarding the proposed amendments to the New Mexico Rule of Evidence 11-901. Please let me know if you have any questions.

Michael J. Dekleva

Associate General Counsel – Risk Management

Presbyterian Healthcare Services

9521 San Mateo Blvd., NE

Albuquerque, New Mexico 87113

Phone: 505.923.6909

Cell: 505.263.7586

Email: mdekleva@phs.org

PRESBYTERIAN

Comment on Proposal Final.pdf
85K

On behalf of Presbyterian Healthcare Services, I write to express concern about the proposed amendments to New Mexico Rule of Evidence 11-901. At the outset I should emphasize that Presbyterian supports the proposal to the extent that it would create a rebuttable presumption of the authenticity of a medical bill that the plaintiff provides to the defendant at least 30 days before trial and identifies at trial. Defendants in medical malpractice cases and other personal-injury lawsuits routinely subpoena medical bills, or obtain releases for them, early in the discovery process. Providers' transmission of the bills directly to defense counsel in response to subpoenas or releases almost always furnishes trustworthy evidence of authenticity. Under these circumstances, Presbyterian agrees that requiring plaintiffs to present the testimony of medical-records custodians at trial increases the costs of litigation without providing any corresponding benefit in the vast majority of cases.

Presbyterian is concerned, however, by the proposed amendments insofar as they would create rebuttable presumptions of "the reasonable and customary nature of the amounts charged" and "the necessity of health care goods and services provided." That proposal seems to us to represent a significant departure from the general principle that plaintiffs bear the burden of proving their claims, and each element of their claims, and from a long-settled and eminently sensible application of the principle in personal-injury cases: "The law is clear that 'a plaintiff seeking admission of medical bills must … establish through expert testimony that medical bills are reasonable and related to the claimed injuries.'" Nelson v. Albuquerque Bernalillo Cnty. Water Util. Auth., Nos. A-1-CA-36495, -36496, mem. op. ¶ 18 (N.M. Ct. App. Mar. 11, 2020) (non-precedential; quoting Segura v. K-Mart Corp., 2003-NMCA-013, ¶ 26, 133 N.M. 192, 62 P.3d 283); accord, e.g., Frei v. Brownlee, 1952-NMSC-099, ¶ 34, 56 N.M. 677, 248 P.2d 671 (holding that chiropractor's bill should have been excluded absent evidence that "the treatments were for a condition caused by injuries received in the wreck"), disapproved in part on other grounds by Dunleavy v. Miller, 1993-NMSC-059, ¶¶ 1–2, 12–26 & n.1, 116 N.M. 353, 862 P.2d 1212; Garcia v. DeLeon, No. A-1-CA-41324, mem. op. ¶ 8 (N.M. Ct. App. Nov. 26, 2025) (non-precedential; citing Segura) ("Plaintiff had the burden of demonstrating, through expert testimony, that her medical expenses were reasonable, necessary, and causally related to the accident."); see also UJI 13-1802, -1804 NMRA (instructing that plaintiff has burden of proving the "reasonable expense of necessary medical care, treatment and services received"). There does not seem to be a justification for such a significant break from the common law. Indeed, no committee commentary is offered to explain it. Nor, for example, does it reflect a comparable revision to Rule 901 of the Federal Rules of Evidence.

Presbyterian recognizes that, technically, the rebuttable presumptions proposed by the amendments wouldn't shift the burden of proof from plaintiffs to defendants; instead they would impose on defendants "the burden of producing evidence to rebut the presumption[s]." Rule 11-301 NMRA. But that nuance does not alleviate Presbyterian's concerns about the proposal. "[U]nder Rule 11-301 a presumption once raised … continues to have evidentiary force, regardless of the contradictory evidence presented by the party against whom it is employed." Chapman v. Varela, 2009-NMSC-041, ¶ 12, 146 N.M. 680, 213 P.3d 1109. Specifically, "the presumption always remains and the basic facts [giving rise to the presumption] can justify a finding of the presumed fact, even if, in the absence of the presumption, the basic facts might not justify such a finding." Id. "Thus, although the raising of the presumption does not mandate any final result at trial, if the fact finder concludes that the party raising the presumption has

prevailed and we find sufficient evidence to support the raising of the presumption, we will not set aside the fact finder's conclusion on appeal." Id. In other words, a rebuttable presumption requires the burdened party to "overcome" the presumption in the eyes of the factfinder. Smith v. Interinsurance Exch. of Auto. Club, 2025-NMSC-004, ¶¶ 2, 6–7, 17, 563 P.3d 868. And if the factfinder finds the presumed fact, the presumption becomes unrebuttable and conclusive on appeal, as long as the predicate facts permitting the presumption are present.

Any such evidentiary effects seem particularly unwarranted with respect to the proposed presumption that particular medical goods and services were "necessary" to treat injuries related to the defendant's alleged negligence. Cf. Frei, 1952-NMSC-099, ¶ 34 (requiring plaintiff to prove that "the treatments were for a condition caused by injuries received in the wreck"); Segura, 2003-NMCA-013, ¶ 26 (requiring plaintiff to prove through expert testimony that medical bills were "related to the claimed injuries"); UJI 13-1802, -1804 (requiring plaintiff to prove that medical care, treatment, and services were "necessary"). The proposal provides that "[i]n any civil action, the necessity of health care goods and services provided to a person shall be rebuttably presumed upon testimony: (a) identifying the health care provider who provided the health care goods and services, and (b) describing the health care goods and services rendered." But these two "basic facts," Chapman, 2009-NMSC-041, ¶ 12 – who provided the care and what it consisted of – do not, by themselves, lead logically or reasonably to an inference that the care was necessary to address injuries caused by the defendant's alleged negligence.

Under the amendments as drafted, for example, a plaintiff could testify that he received two years of twice-a-week spinal manipulations from his chiropractor, and could recover the billed charges for them in a lawsuit against a radiologist for failure to diagnose a lung cancer. Or conversely, he could testify that he received half a million dollars' worth of immunotherapy, radiation oncology, and surgery, and could recover the billed charges for them in a lawsuit growing out of an intersection collision. The language of the proposed amendments requires no evidence that there was any connection between the described services and the negligence at issue.

And while the common sense of the jury would presumably guard against awards for unrelated care in these extreme scenarios, other dubious claims would be far more difficult for the jury to identify. Suppose that a plaintiff "identif[ies]" the skilled nursing facility where he spent five months recovering from both COVID-caused sepsis and a bedsore he allegedly developed in the defendant hospital's intensive care unit beforehand, and suppose that he generally "describ[es]" the extensive care he received in the skilled nursing facility, which included debridement of the bedsore along with respiratory, physical, and occupational therapy to rehabilitate the plaintiff from his sepsis. Or suppose that the plaintiff identifies a physician and describes the completely experimental and outlandishly expensive therapy that the physician provided to him – in lieu of a proven treatment prescribed by the prevailing standard of care – for a condition allegedly attributable to the defendant's malpractice. In the first situation, the rebuttable presumption would permit the jury to award the entire cost of the stay in the skilled nursing facility, though much of it had nothing to do with the bedsore; and in the second situation, the presumption would permit the jury to compensate the plaintiff for services that no reasonable jury could deem "necessary." In both cases, to be sure, the defendant would be entitled to introduce expert testimony disputing the notion that the services at issue were

necessary to treat injuries related to the defendant's claimed negligence. But even in the absence of any evidence from the plaintiff tending to demonstrate necessity and relatedness, the jury would be entitled to rely on the presumption – and the jury's reliance would be unassailable on appeal, as long as the record contained testimony identifying the provider and describing the treatment.

Again, what would justify such outcomes? The legislature or this Court typically fashions rebuttable presumptions for situations in which assigning a burden of proof would be unfair, or for other public-policy reasons. See, e.g., Chapman, 2009-NMSC-041, ¶ 13 (observing that presumption of undue influence was created because "direct proof is notoriously elusive"); Stanley v. N.M. Game Comm'n, 2024-NMCA-006, ¶ 19, 539 P.3d 1224 ("Because adverse use may be difficult to prove due to the passage of time, the law allows for a presumption of adverse use where all the other elements of a prescriptive easement are met and there is no evidence of express or implied permission by the landowner."); State v. DeAngelo M., 2015-NMCA-019, ¶ 9, 344 P.3d 1019 ("The Children's Code protects children younger than fifteen years old by creating a rebuttable presumption that statements given by thirteen- or fourteen-year-old children are inadmissible."), aff'd in relevant part, 2015-NMSC-033, ¶¶ 4–14, 360 P.3d 1151. But there is no conceivable unfairness in requiring a plaintiff to introduce at least a modicum of evidence that the medical care for which he seeks compensation was made necessary by the negligence he alleges. Nor is the proposed presumption necessary to remedy any perceived economic imbalance between plaintiffs as a class and defendants; the expenses associated with proof of relatedness will ordinarily be recoverable by a prevailing plaintiff under Rule 1-037(C) NMRA or Rule 1-054(D)(2)(g) NMRA.

Finally, even if rebuttable presumptions of the reasonableness and necessity of medical care were otherwise defensible, the procedural safeguards proposed by the drafters would be inadequate. The proposed rule would allow a plaintiff to invoke the presumption of reasonableness by giving the defendant 30 days' notice before trial – long after lapse of the usual scheduling-order deadline for identifying the experts a defendant would need in order to combat the presumption. And the proposed presumption of necessity would be even more susceptible to sandbagging; the plaintiff could activate it merely by identifying health care providers and describing their services when he takes the stand at trial.

For these reasons, on behalf of Presbyterian, I urge the Court to reject the proposed amendments except to the extent that they would create a rebuttable presumption that medical bills are authentic.

New Mexico Courts

Alyssa Segura <supams@nmcourts.gov>

[rules.supremecourt-grp] Comment to Recommended Amendment to Rule 11-901(C)

'ALLISON BEAULIEU' via Supreme Court Rules <rules.supremecourt-grp@nmcourts.gov> Sat, Apr 4, 2026 at 4:14 PM
Reply-To: abeaulieu@jshfirm.com
To: "rules.supremecourt@nmcourts.gov" <rules.supremecourt@nmcourts.gov>

Ms. Garcia,

On behalf of the NMDLA, please find attached comments regarding the recommended amendment to Rule 11-901(C).

Sincerely,

JSH JSHFIRM.COM

ALLISON M. BEAULIEU | Partner
Jones, Skelton & Hochuli, P.L.C.
8220 San Pedro Dr NE, Suite 420 | Albuquerque, NM 87113
P (505) 339-3517 | **F** (505) 339-3211

website | bio | vCard | map | email | linkedin | facebook | twitter

NMDLA Response to Proposed Amendment to 11-901(C).pdf
159K

NEW MEXICO Defense Lawyers Association

Please accept this as a formal comment by the New Mexico Defense Lawyers Association ("NMDLA") regarding proposed amendment to Rule 11-901(C).

This proposed rule change represents a clear attempt to favor plaintiffs in personal injury litigation within our state. Not only does it shift the longstanding burden, which requires plaintiffs to prove every essential element of their claim by the greater weight of the evidence (Rule 13-304 NMRA), it also incentivizes predatory practices[1] and encourages potential plaintiffs to seek unnecessary treatment.

The NMDLA is also concerned that this rule seeks to undo some of the recent changes enacted by HB 99 (Medical Malpractice Act). The amendments to the Medical Malpractice Act demonstrated clear public policy interest in making litigation against medical providers fair with reasonable limitations, a position largely supported by the public. We note that the current Chair of the Rules of Evidence Committee was a vocal opponent of the medical malpractice reform legislation[2]. Now, we have a proposed rule that seeks to continue to make it more difficult for medical providers to defend against cases, undoing the work the legislature committed to changing, and seeks to do so without public comment or the public's knowledge.

This rule does not only affect medical providers; it impacts all business owners, governmental entities, and any organization or individual that may be subject to personal injury lawsuits. The proposed change imposes additional burdens on defendants generally. The increased cost of litigation and added challenges for defendants will ultimately result in higher insurance premiums across the state.

When attorneys on one side of litigation react with shock and outrage to the significant changes a rule would bring, the judiciary should carefully consider whether the rule change is neutral or creates an imbalance of power. This rule, in its current form, is not neutral and not only reverses recent legislation, but also undermines established rules and law concerning the burden of proof in these cases. Therefore, the NMDLA respectfully requests that this rule not be adopted.

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[1] George A. Nation III, *The Valuation of Medical Expense Damages in Tort: Debunking the Myth That Chargemaster-Based "Billed Charges" Are Relevant to Determining the Reasonable Value of Medical Care*, 95 Tul. L. Rev. 937 (2021).

[2] Clara Bates & Margaret O'Hara, *Negotiations on Medical Malpractice Bill Stall over Punitive Damages*, Santa Fe N.M., Jan. 30, 2026, https://www.santafenewmexican.com/news/legislature/negotiations-on-medical-malpractice-bill-stall-over-punitive-damages/article_c1b9055c-7304-4d4c-92f4-4a068b3f99b0.html; Ed Williams, *The Dark Money Group Fighting Malpractice Reform in New Mexico's 2025 Legislature*, Searchlight N.M. (Feb. 25, 2025), https://searchlightnm.org/dark-money-fighting-malpractice-reform-new-mexico-2025-legislature/.

New Mexico Courts

Alyssa Segura <supams@nmcourts.gov>

[rules.supremecourt-grp] Comment to Recommended Amendment to Rule 11-901(C)

'ALLISON BEAULIEU' via Supreme Court Rules <rules.supremecourt-grp@nmcourts.gov> Sat, Apr 4, 2026 at 4:38 PM
Reply-To: abeaulieu@jshfirm.com
To: "rules.supremecourt@nmcourts.gov" <rules.supremecourt@nmcourts.gov>

Ms. Garcia,

I am also submitting a comment personally regarding the proposed amendment to Rule 11-901(C).

This rule change will greatly benefit plaintiffs while making it more difficult for defendants to defend against personal injury claims. From the brief research I was able to conduct regarding this rule, only a handful of states have similar rules. I reached out to a colleague in Wisconsin where they have a similar rule. She sees more cases of plaintiffs overtreating and finds that it is extraordinarily rare to successfully rebut any of these presumptions. Our state has seen a drastic increase in jury verdicts in the last decade. The cost of litigating cases has increased tremendously. The willingness of plaintiffs to negotiate cases reasonably decreases by the year because there are already so many things about practice in New Mexico that are favorable for them. I'm very concerned that this rule change will increase verdicts, increase the cost of litigation, and increase the number of cases that go to trial.

The rules should even the playing field for litigants. This rule does the opposite. Please don't accept the proposed amendment.

Sincerely,

JS&H JSHFIRM.COM

ALLISON M. BEAULIEU | Partner
Jones, Skelton & Hochuli, P.L.C.
8220 San Pedro Dr NE, Suite 420 | Albuquerque, NM 87113
P (505) 339-3517 | **F** (505) 339-3211

website | bio | vCard | map | email | linkedin | facebook | twitter

[Quoted text hidden]

New Mexico Courts

Alyssa Segura <supams@nmcourts.gov>

[rules.supremecourt-grp] Open for Comment Form submitted on Supreme Court

Supreme Court <noreply@nmcourts.gov> Sun, Apr 5, 2026 at 2:16 PM
Reply-To: noreply@nmcourts.gov
To: rules.supremecourt@nmcourts.gov

Name	Elizabeth
	Perkins
Phone Number	5057857012
Email	elizabeth.perkins@qpwblaw.com
Proposal Number	2026-022
Comment	I write to oppose this proposed change to the rule. It is foundational to our justice system that the party bringing the case has the burden of proving all the elements of the claim. To include language in the rule that amounts charged by providers is presumed to be reasonable and customary is the most problematic. I have seen clinics who largely treat people on letters of protection stemming from attorney referrals charge $1700 for a 20 minute zoom consultation. The party claiming this fee is reasonable and customary should have to prove as much. This rule change will not decrease the need for litigation over medical bills, it only undermines the requirement that the plaintiff prove every element of their claim. In addition I support the comment made by NMDLA and agree with its reasoning.

New Mexico Courts

Alyssa Segura <supams@nmcourts.gov>

[rules.supremecourt-grp] Open for Comment Form submitted on Supreme Court

Supreme Court <noreply@nmcourts.gov> Sun, Apr 5, 2026 at 4:06 PM
Reply-To: noreply@nmcourts.gov
To: rules.supremecourt@nmcourts.gov

Name	Sean
	Garrett
Phone Number	5052663995
Email	sgarrett@ylawfirm.com
Proposal Number	Proposal 2026-022 - Medical Billing
Comment	Comment attached.
File Upload	https://supremecourt.nmcourts.gov/wp-content/uploads/sites/2/formidable/6/Comment-on-Proposed-Rule-Change-2026-022-Medical-Billing.pdf

Comment-on-Proposed-Rule-Change-2026-022-Medical-Billing.pdf
148K

YLAW
ATTORNEYS

April 5, 2026

VIA ELECTRONIC MAIL: rules.supremecourt@nmcourts.gov
Elizabeth A. Garcia
New Mexico Supreme Court
PO Box 848
Santa Fe NM 87504

Re: *Proposed Revisions to New Mexico Rule of Evidence 11-901*
Proposal 2026-022 - Medical Billing

Dear Ms. Garcia:

It is a bedrock principle of New Mexico law that a plaintiff in a civil lawsuit bears the burden of proving causation and damages. Proposal 2026-022 seeks to upend the burden of proof by requiring the defendant to disprove two essential elements of a plaintiff's tort claim. The only conceivable purpose of such a rule change is to make it easier for the plaintiff to meet his or her burden of proof at trial while requiring the defendant, at additional expense, to disprove a presumption of reasonable and necessary medical treatment.

This Proposal's presumption that prices reflected on a medical invoice constitute "reasonable and customary" amounts shifts the burden of proof on damages and runs contrary to prevailing trends across the country. The purpose of compensatory damages is to compensate a plaintiff for a loss *actually* incurred. Instructing the jury that medical invoices are presumed to reflect "reasonable and customary" amounts for the treatment rendered absolves the plaintiff of his or her obligation to prove damages. Healthcare providers can select any arbitrary amount as the "price" for a given service, often knowing they will receive less than that amount as full payment. This Proposal would incentivize unscrupulous providers to inflate the amount they charge for a service because it would benefit the plaintiff and the provider's ultimate recovery. A provider could bill an amount to presumptively increase the value of the plaintiff's case while understanding such amount is not expected to, and will never, be paid. This is already common practice in personal injury litigation.

Additionally, a growing number of states recognize that modern insurance practices render the amount billed by a provider as inflated and arbitrary and, thus, poor evidence of the "reasonable and customary" value of treatment. "[H]ospital chargemasters have become increasingly arbitrary and, over time, have lost any direct connection to hospitals' actual costs, reflecting, instead, inflated rates set to produce a targeted amount of profit for the hospitals after factoring in discounts negotiated with private and governmental insurers." *French v. Centura Health Corp.*, 2022 CO 20, ¶ 40, 509 P.3d 443, 451–52 (Co. 2022). California, Utah, and Delaware all have recent opinions stating that the amount paid is better evidence of the "reasonable and customary" value of treatment. *Howell v. Hamilton Meats & Provisions, Inc.*, 52 Cal. 4th 541, 257 P.3d 1130 (Cal. 2011); *Gardner v. Norman*, 2025 UT 47, 582 P.3d 717 (Utah

2025); *Smith v. Mahoney*, 150 A.3d 1200 (Del. 2016). Texas, Oklahoma, Montana, and Missouri have codified such an approach. Other states, including Ohio, Indiana, Kansas, and South Carolina, allow evidence of both billed and paid, thus allowing the jury to determine the "reasonable and customary" value of treatment.

The rationale for the foregoing is the inflated and arbitrary fiction created by insurance and certain provider practices. If the public is not willing to pay the price billed (whether through public benefit programs, insurance, or private payment), and a plaintiff is never required to pay that amount for the same reason, then the amount billed is simply an artifice. Inflated charges which have never been and will never be paid by a plaintiff or his or her insurer do not compensate the plaintiff for a loss incurred. Yet, the Proposal would unfairly place the burden on the defendant to make this showing, further impeding a defendant's right to a fair civil trial in New Mexico.

Indeed, the "reasonable and customary" presumption may implicate constitutional concerns. The Proposal creates the default position that the amount billed should be awarded for medical expenses. The defendant would be required to prove that the amounts billed were not paid by the plaintiff, are not owed by the plaintiff, and will never be collected from the plaintiff. Moreover, the defendant would be required to prove that the amount billed does not necessarily reflect the true or reasonable value of a given medical procedure. Given how New Mexico courts have historically broadly and strictly applied the collateral source doctrine, how would defendants rebut a presumption of "reasonable and customary"? The Proposal would inevitably mislead the jury into awarding damages the plaintiff did not incur and that do not reflect the value of treatment rendered. Rather than compensating a plaintiff, awards of billed amounts punish the defendant without requiring a showing of malfeasance. In other words, a defendant in a civil suit is the only person or entity who would ever pay the *billed* amount for medical care.

The Proposal's presumption that health care goods and services received (as reflected on billing) were "medically necessary" also shifts the burden of proof on causation. Healthcare providers often treat conditions or injuries that were not caused by the subject tort, sometimes during the same appointment (e.g., a plaintiff seeing her or her primary care provider for a cold and back pain attributable to a tort). Under the Proposal, the plaintiff would be able to submit bills for any number of unrelated medical conditions and compel the defendant to parse and prove that certain treatment was not necessitated by the defendant's alleged tortious acts. Instead of requiring the plaintiff to prove medical causation, the Proposal would require the defendant to disprove it. In other words, the Proposal would require the defendant to call providers or experts to develop evidence that treatment reflected on medical billing was *not* necessary, instead of the current burden, which requires a plaintiff to call providers or experts to prove treatment was necessary.

Additionally, a presumption that health care goods and services received were "medically necessary" implicates public policy concerns by encouraging healthcare providers (especially unscrupulous providers on a referral from a plaintiffs' attorney) to subject patients to unnecessary, costly, and potentially harmful diagnostic testing, treatment, and procedures. The Proposal would foster collusion between attorneys and unscrupulous healthcare providers desiring to inflate damages awards without regard for the health and safety of the plaintiff. This is another practice currently seen in personal injury litigation.

A "plaintiff seeking admission of medical bills must not only establish through reasonable expert testimony that medical bills are reasonable and related to the claimed injuries," but must also "lay a foundation establishing an exception to the hearsay rule." *Segura v. K-Mart Corp*., 2003-NMCA-013, ¶ 26. Proposal 2026-022 advocates a dramatic and fundamental restructuring of New Mexico tort law. Using the rulemaking process for a major shift in New Mexico law is improper. Such change should only be achieved through judicial deliberation and application of *stare decisis*.

We appreciate the opportunity to provide comment on Proposal 2026-022 and the proposed change to Rule 11-901. For the foregoing reasons, we respectfully request that the Court reject the proposed change.

Sincerely,

YLAW, P.C.

/s/ S. Carolyn Ramos
S. Carolyn Ramos
Sean E. Garrett

New Mexico Courts

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Alyssa Segura <supams@nmcourts.gov>

[rules.supremecourt-grp] Open for Comment Form submitted on Supreme Court

Supreme Court <noreply@nmcourts.gov> Mon, Apr 6, 2026 at 9:49 AM
Reply-To: noreply@nmcourts.gov
To: rules.supremecourt@nmcourts.gov

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Proposal Number	2026-022
Comment	Medical bills and records are used and presumptively considered authentic by Defense lawyers, who still insist that Plaintiffs call records custodians to prove the authenticity of the same, even those same records used by the Defense. Falsification of medical bills is so vanishingly rare as to not be a reasonable basis for the rule as it exists now. This change will result in considerably less litigation, less unnecessary expense of calling custodians, and less stress on an already overburdened court to have to conduct hearings so that a line of records custodians can simply attest that, yes, the records they are reviewing are true and correct copies of what they purport to be.