NOT FOR PUBLICATION
WITHOUT THE APPROVAL OF THE COMMITTEE ON OPINIONS

	: SUPERIOR COURT OF NEW JERSEY
MIKE CHARLES, a minor, by his G.A.L. EMMANIA CHARLES and EMMANIA CHARLES, Individually	:
Plaintiff(s)	:
	: ESSEX COUNTY
v.	: DOCKET NO.: ESX-L-9911-13
	: **OPINION**
SAMUEL THOMAS, M.D., MERIDIAN HEALTH, MERIDIAN PEDIATRIC ASSOCIATES, JERSEY SHORE UNIVERSITY MEDICAL CENTER, SAMUEL ENGEL, M.D., COASTAL EAR NOSE AND THROAT LLC, JEFFREY WU, M.D., JERSEY SHORE ANESTHISIOLOGY ASSOCIATES P.A., ELIZABETH CZAR, D.O., BETH ANN MCKEOWN, R.N. and John Does 2-10 and Jane Does 1-10 (representing presently unknown health care providers, including but not limited to doctors, nurses, technicians, etc.) and ABC Corporations 2-10 (representing presently unknown facilities or entities who rendered care to the plaintiff)	:
Defendants.	:

Oral argument was heard by the court on September 30, 2016. The following attorneys are counsel of record:

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Decided: October 3, 2016

By: Thomas R. Vena, J.S.C.

PRELIMINARY STATEMENT

This matter comes before the court on Defendants' motion to limit the admissibility of Plaintiff's medical bills. Defendants argue that Plaintiff should not be permitted to introduce into evidence the amount Plaintiff's health providers billed him following Plaintiff's tragic cardiopulmonary arrest and the resulting complications therefrom. Instead, Defendants contend that Plaintiff should only be permitted to introduce into evidence the amount of the medical bills that Medicaid paid for – $239,695.67 – which, in turn, is the amount Plaintiff owes to Medicaid should Plaintiff prevail in this lawsuit. Defendants' theory is that this figure most accurately reflects Plaintiff's loss. Plaintiff, on the other hand, argues that the original billed amount reflects the amount of medical expenses incurred, and as such, should be admissible so as to more fully inform the jury as to the extent of Plaintiff's injuries resulting from his heartbreaking ordeal.

STATEMENT OF FACTS

The facts underlying this motion are not extensive. The Infant-Plaintiff, Mike Charles, alleges that he was injured as a result of Defendants' negligence during a routine Ear, Nose and Throat procedure on February 26, 2013. Plaintiff suffered cardiopulmonary arrest following this ENT procedure. It is alleged that this resulted in Plaintiff developing hypoxic ischemic encephalopathy, cortical blindness, developmental delays, and seizure disorders. Medicaid paid $239,695.67 in full satisfaction of Plaintiff's medical bills. This amount paid for by Medicaid is significantly lower than the amount Plaintiff's health providers originally billed. This discrepancy notwithstanding, it is

undisputed that Plaintiff does not owe any amount, to any provider, beyond the $239,695.67 payable to Medicaid.

LEGAL ANALYSIS

Defendants argue that Plaintiff should not be permitted to introduce into evidence the amount Plaintiff's health providers billed him following Plaintiff's tragic cardiopulmonary arrest and the treatment provided to Plaintiff as a result. Instead, Defendants argue that Plaintiff should only be permitted to introduce into evidence the amount of the medical bills that Medicaid paid for: $239,695.67. This amount represents what Plaintiff owes Medicaid. Defendants' theory is that this figure most accurately reflects Plaintiff's loss. Conversely, Plaintiff argues that the original billed amount represents the medical expenses incurred, and therefore, should be admissible.

A. The Overarching Purpose of Tort Law is to Make Plaintiffs Whole by Compensating Them For Actual Losses and Expenses

The Supreme Court of New Jersey has stated that, in contemplating fairness in calculating a plaintiff's award stemming from a personal injury action, such calculation should be limited to "no more than will make the plaintiff whole, that is, the actual loss." Caldwell v. Haynes, 136 N.J. 422, 433 (1994).

In this case, in the event Plaintiff prevails, Medicaid will be entitled to recover the $239,695.67 it paid for Plaintiff's medical expenses. Thus, it is clear that in keeping with the purpose of tort law under Caldwell, Plaintiff's actual loss – that which must be provided to Plaintiff so as to make him whole – is that which must be reimbursed to Medicaid.

B. The Common Law Collateral Source Rule, the Enactment of N.J.S.A. 2A:15-97, and the Resulting Law: Medicaid is Not a Collateral Source

Prior to the enactment of the Collateral Source Statute, N.J.S.A. 2:A15-97, and under the common-law collateral source rule, a tort victim was permitted to retain benefits from non-defendants, i.e., insurance payments, along with amounts the victim recovered from the defendant. Kiss v. Jacob, 138 N.J. 278, 281 (1994). By passing N.J.S.A. 2:A15-97, the New Jersey Legislature intended to eliminate the collateral source rule in Tort law. The statute provides as follows:

> In any civil action brought for personal injury or death, except actions brought pursuant to the provisions of P.L.1972, c. 70 (C. 39:6A-1 et seq.), if a plaintiff receives or is entitled to receive benefits for the injuries allegedly incurred from any other source other than a joint tortfeasor, the benefits, other than workers' compensation benefits or the proceeds from a life insurance policy, shall be disclosed to the court and the amount thereof which duplicates any benefit contained in the award shall be deducted from any award recovered by the plaintiff, less any premium paid to an insurer directly by the plaintiff or by any member of the plaintiff's family on behalf of the plaintiff for the policy period during which the benefits are payable. Any party to the action shall be permitted to introduce evidence regarding any of the matters described in this act.
>
> N.J.S.A. 2A:15-97.

The Supreme Court of New Jersey has made it clear that this statute's purpose is to prevent plaintiffs from achieving "double recovery." Kiss v. Jacob, 138 N.J. 278 at 281.

In Lusby by & ex rel. Nichols v. Hitchner, the court was tasked with reconciling N.J.S.A. 2A:15-97 and N.J.S.A. 30:4D-7.1, which required benefits received by Medicaid be reimbursed from a tort recovery. Lusby by & ex rel. Nichols v. Hitchner, 273 N.J. Super. 578, 591 (App. Div. 1994). The court concluded that N.J.S.A. 2A:15-97 "does not apply to reimbursable benefits paid by Medicaid." Id. at 590. In other words, Medicaid

benefits are not collateral sources within N.J.S.A. 2A:15-97, and thus, not subject to deduction. Id. at 591-592.

In this case, Plaintiff attempts to argue that Defendants are arguing for an improper pre-verdict molding of an award. In reality, Defendants are not making this argument. An argument that the original medical bills should be excluded from evidence and an argument for a pre-verdict collateral source deduction – a pre-verdict molding of an award – is not the same.

The dispute between Plaintiff and Defendants does not lie in the timing of the court's potential molding of an award. Rather, the dispute concerns the introduction of medical bill evidence to the jury. Moreover, because Medicaid benefits are not deducted from awards, as they fall outside the scope of N.J.S.A. 2A:15-97, Plaintiff's argument is without merit. Accordingly, Plaintiff's argument must fail.

C. Although Courts Have Not Spoken to The Meaning of "Incurred" within N.J.S.A. 2A:15-97, the Inquiry is Not Unsolvable

The court remains cognizant that simply because Medicaid is not a collateral source, the issue of what medical expenses Plaintiff "incurred" for the purposes of N.J.S.A. 2A:15-97 is still contested. The arguments from each of the parties are clear. Plaintiff contends he incurred expenses equivalent to the amount which was originally billed. Defendants contend that Plaintiff's incurred expenses are those which Medicaid paid and which the providers accepted as payment in full.

As Plaintiff notes in his opposition, the statute "places no restriction on a party introducing, for the jury's consideration, evidence of the total amount of medical bills incurred." Dias v. A.J. Seabra's Supermarket, 310 N.J. Super. 99, 102, 707 A.2d 1391

(App. Div. 1998). The question becomes then, and the issue here is, what the definition of the word "incurred" is within the statute.

When presented with conflicting interpretations of the same word, courts "are to give words their common and ordinary meaning, unless instruction in the statute dictates otherwise." Great Atlantic and Pacific Tea Co., Inc. v. Borough of Point Pleasant, 137 N.J. 136, 644 A.2d 598 (1994). The word "incur" is defined as "to become liable or subject to." Webster's Seventh New Collegiate Dictionary, G. & C. Merriam, Co.: Springfield, Massachusetts, 1969. Furthermore, the statute does not provide that "incur" should be defined any other way.

In this case, Plaintiff is only liable to Medicaid to the extent of $239,695.67, the amount Plaintiff's providers accepted as payment in full for their services. It is undisputed that Plaintiff does not owe any provider any other sum of money. Therefore, Plaintiff has "incurred" only the amount he is liable to Medicaid for: $239,695.67.

D. The Same Conclusion the Court Arrives at Today Has Previously Been Reached by the Appellate Division

The court is fully aware of the direction R. 1:36-3 provides with respect to unpublished opinions. This rule notwithstanding, the Appellate Division had made clear that while unpublished opinions are not binding, trial courts are nevertheless permitted to consider the analyses set forth in unpublished opinions, find them persuasive, and use such analyses as guideposts in reaching their conclusions. National Union Fire Ins. Co. of Pittsburgh v. Jeffers, 381 N.J. Super. 13, 19 (App. Div. 2005).

Accordingly, this court looks to an unpublished opinion from the Appellate Division where the plaintiff alleged that he broke his femur due to the negligence of the defendants. Ribeiro v. Sintra, 2008 N.J. Super. Unpub. LEXIS 771 at *2, (App. Div. July

10, 2008). The plaintiff was billed $178,914.27 in medical expenses from his providers. Id. at *4. The providers accepted $25,420.37 from the plaintiff's health insurance company as payment in full. Id.

The plaintiff argued that the jury be informed as to the billed amount, $178,914.27, while the defendant argued that the jury only be told of the $25,420.37, which had been paid by the plaintiff's insurer and had been accepted as payment in full by the plaintiff's providers. Id. at *5. The trial judge excluded both figures. Id. The plaintiff appealed and argued that the trial judge improperly barred the medical bills from evidence. Id.

The Appellate Division, after noting that the purpose of N.J.S.A. 2A:15-97 is to prevent double recovery, noted that "[t]he statute places no restriction on a party introducing, for the jury's consideration, evidence of the total amount of medical bills incurred." Id. at *6, citing Dias v. A.J. Seabra's Supermarket, 310 N.J. Super. 99, 102, 707 A.2d 1391 (App. Div. 1998). The Appellate Division went on to note that the statute requires that courts must allow the juries to consider "the full amount incurred." Id.

The Appellate Division then reversed the trial court, and in-so doing, held that "Medical expenses incurred are equivalent to that amount accepted by the medical provider in full payment for their services, rather than the actual amount stated in the bill." Id. at *7.

The facts of this case mirror those of Ribeiro. As such, and in full accordance with National Union Fire Ins. Co. of Pittsburgh, this court finds the reasoning within Ribeiro to be persuasive, and we reach the same conclusion the Ribeiro court did. As in Ribeiro, this case seemingly turns on the meaning of "incurred" within N.J.S.A. 2A:15-

97. Plaintiff wishes to introduce into evidence the total amount of medical expenses which were originally billed, a number that is not specified. Defendants seek to limit the evidence to the amount Medicaid paid and the providers accepted as full payment for their services, $239,695.67.

As stated above, Ribeiro provides the pertinent guidance. Thus, as in Ribeiro, Plaintiff here is permitted to introduce into evidence only the loss he actually incurred – in other words, the amount accepted by his providers as payment in full for their services. In this case, that amount is the $239,695.67 that Medicaid paid to Plaintiff's providers and which they accepted as payment in full.

E. Dias, the Case Upon Which Plaintiff Relies, Underscores Defendants' Argument

Plaintiff's reliance on Dias v. A.J. Seabra's Supermarket in his opposition to Defendants' motion is not persuasive. In that case, as Plaintiff notes, the parties stipulated that the total medical expenses were $106,006.67. Insurance paid $76,106.04 of that amount, but $29,900.63 remained payable to the providers. Dias, 310 N.J. Super. 99, 101, 707 A.2d 1391 (App. Div. 1998). In other words, the providers in Dias did not accept the insurance payment as payment in full for the medical services they rendered.

The trial court only permitted the jury to consider the outstanding $29,900.63. Id. Thus, the jury did not hear about the $76,106.04 which had indeed been incurred by the plaintiff, and which, as a result, insurance had paid. The Appellate Division, in reversing, held that "any required adjustment in a party's ultimate recovery is to be made by the court, after the jury has considered the full amount incurred." Id. at 102. Therefore, the plaintiff in Dias was entitled to inform the jury about the $106,006.07, as this figure reflected the total amount incurred by the plaintiff. Id.

The instant case is not analogous to Dias. In the instant case, following Plaintiff's insurance's payment of $239,695.67, no amount remained outstanding to Plaintiff's providers, as unlike in Dias, the providers here accepted Plaintiff's insurance payment of $239,695.67 as payment in full for the services rendered.

Moreover, the dispute in Dias concerned whether the jury would be told of the amount of the bills that the insurance had already paid: the $76,106.04 of the $106,006.67. Here, the parties do not dispute that Plaintiff will be entitled to inform the jury of the amount the insurance has paid: the $239,695.67.

Finally, Dias actually provides support for Defendants' argument, as it demonstrates that the Appellate Division views the amount incurred by a plaintiff as the amount the plaintiff's insurance pays, plus any outstanding amount owed to providers. In this case, Plaintiff's insurance paid a certain amount to Plaintiff's providers, and no outstanding amount exists. Therefore, Plaintiff's total amount incurred is the amount his insurance paid, and his reliance on Dias is misplaced.

CONCLUSION

For the foregoing reasons and on the basis of the authority cited herein, the Defendants' motion to limit the admissibility of medical bills is **GRANTED**.

Very Truly Yours,

The Honorable Thomas R. Vena, J.S.C.