IN THE CIRCUIT COURT OF THE NINTH JUDICIAL CIRCUIT, IN AND FOR ORANGE COUNTY, FLORIDA

CASE NO: 2012-CA-6088-O

KELLY GARRETT,

Plaintiff,

vs.

ALBERTSON'S LLC, A FOREIGN LIMITED LIABILITY COMPANY,

Defendant.
_____ /

PLAINTIFF'S MOTION IN LIMINE TO EXCLUDE OR LIMIT THE TESTIMONY OF DEFENDANT'S "BILLING CODE" EXPERT, JEREMY REIMER

COMES NOW the Plaintiff, KELLY GARRETT, by and through her undersigned counsel and moves this Honorable Court for an order *in limine* to exclude or limit the testimony of Defendant's "billing code" expert, Jeremy Reimer, on the following grounds:

I. Testimony At Issue:

In this case, Defendant is proffering the testimony of Jeremy Reimer, a purported expert in medical billing codes and standards. The American Association of Professional Coders certifies Jeremy Reimer as a professional medical billing coder. He is not a medical doctor or any other kind of health care provider, nor has he ever worked in the billing department, or any other department, of any health care provider or hospital. He has not had any training in medical ethics, does not hold himself out as an expert in medical ethics, and is not a member of the American Medical Association. He has never worked in a health care provider's billing office. He has never worked as a nurse or nurse's aide. He does not hold himself out as an expert in any

medical standards. Mr. Reimer says he received a degree in finance from the University of North Florida in 1998, got his certification in medical coding in 2010 or 2011, and worked in medical coding beginning in about 2003 for a reinsurance broker analyzing health insurance and government health plan claims for some years prior to receiving his certification. (Reimer Deposition Volume 1, Pages 1-14, 75-76, 81).

Jeremy Reimer seeks to testify that certain medical codes were erroneous and/or didn't match the services provided in the medical records and/or that certain billing codes and invoices ran afoul of regulations, standards, and guides purportedly used by professional coders in analyzing bills for medical services for health insurers and government health plans. Perhaps most importantly, he seeks to testify that certain medical bills are excessive or unreasonable based upon an analysis he performed (which is based upon his own definition of "usual, customary, and reasonable" amounts and by reference to a national database of medical billing data gathered by "Fair Health" which Mr. Reimer admits is billing data obtained only from health insurers). Mr. Reimer has done no surveys of health care providers in Central Florida pertaining to medical billing or rates. He acknowledges that there is no universally accepted definition of what "usual, customary and reasonable" medical charges are in the American healthcare system. (See Reimer Deposition, Volume 1, Pages 109-116, Reimer's Report attached to his deposition). While he purports to identify regulations and statutes that require the use of CPT (current procedural technology) coding whether or not health insurance or government plans are payors in a particular patient's case, he says that it is industry standard to use the codes in documenting procedures performed and services provided, regardless of payor. At the same time, he acknowledges that each "health plan" would have its own rules on what amount was "reimbursable" or "payable" on behalf of a patient to a health care provider. Yet, he applies the

rules and regulations pertaining to "code" based billing to self-pay patients including upcoding, unbundling, and the like. (Deposition of Reimer, Volume 2, Pages 131-132). Likewise, he acknowledges that in Ms. Garrett's case, there is no health plan or insurer to determine the amount of any particular bill that is reimbursable or payable on her behalf, obviously because she is not "covered". Indeed, he asserts that HE is performing that analysis for her. He considers it his role, in that regard, to determine "reasonableness" of the bills submitted to her. He proposes to do this, in front of a jury, applying his own formula which includes the following two step analysis:

(A) Determine whether the health care provider has complied with CPT codes, regulations, and standards that he has analyzed;

(B) Apply to those bills that he determines to be "allowable" his own usual, customary and reasonable calculus, i.e. anything not in excess of the 75th percentile billing data contained in the "Fair Health" database which, by definition, excludes purely self-pay billing and includes only data submitted to "Fair Health" by health insurers and health plans.

(Deposition of Reimer, Volume 2, Pages 133-136). Again, he acknowledges that there is no universal definition of "usual, customary and reasonable" that applies to self-pay patients; rather, he has devised his own definition. If there was a standard industry definition of "reasonableness", he would have instead relied upon it. Moreover, his definition is not published or peer reviewed. (Deposition of Reimer, Volume 2, Pages 136-147).

Mr. Reimer further takes the position that if "coding" is incorrect or inaccurate in the case of a self-pay patient, the patient does not owe the medical bill and does not have to pay it. He acknowledges that he does not know the legal consequences or possibilities of nonpayment by a

self-pay patient, but maintains the bills are not owed. (Deposition of Reimer, Volume 2, Pages 149-198).

Jeremy Reimer further seeks to testify that physicians who treated Plaintiff violated American Medical Association (AMA) Ethics rules by having "contingent fee" agreements and by failing to document disclosure to the patient of the one physician's ownership in a surgery center at which Plaintiff's surgery was performed. (See Reimer's Report attached to his deposition).

At all material times, Plaintiff had no health insurance, was not eligible for Medicare, was not entitled to Medicare medical benefits, never received any Medicare benefits, was not eligible for Medicaid (until recently after virtually all the bills were incurred), was not entitled to Medicaid benefits, never received any Medicaid benefits, and never was eligible for or received any medical benefits from any private or public medical benefits or insurance coverage plan.

II. Leading Case Law on Admissibility of Billing Code Expert Testimony in Liability Cases:

There are two leading cases addressing the admissibility of expert testimony of purported "billing code professionals" in the context of a liability claim, such as the instant case, as opposed to admissibility of such testimony in first party health insurance or government health plan litigation or disputes.

In State Farm Mutual Automobile Insurance Company v. Bowling, 81 So.3d 538 (Fla. 2nd DCA 2012), the testimony of the billing code expert was that "the bills did not correlate to the treatment in the medical records" and her expertise was that she had "specialized knowledge and training to express an opinion on whether the medical bills were *properly coded and whether*

they correspond[ed]to the medical records documenting the purported treatment." Id. at 540. Nothing in Bowling supports Defendant's contention that such an expert can provide expert opinion testimony on the reasonableness of medical expenses. In holding it was error to exclude the billing code expert's opinion to be error, the Second District Court of Appeal stated: "While Ms. Pacha *does not have the necessary medical background to render an opinion on whether the medical care allegedly provided to Mr. Bowling was reasonable*, *she does have the requisite skill and training to render an opinion on whether the bills submitted by his medical providers accurately reflect the care documented in the medical records* of those same providers. This was directly relevant to the amount of damages claimed by the Bowlings." Id. at 541. Thus, the holding in Bowling is quite limited in permitting the testimony for the sole purpose of determining whether the care documented in the medical records and the care referenced in the medical bills are accurate reflections of one another.[1]

In Castellanos v. Target Corporation, 568 Fed. Appx. 886 (11th Cir. 2014), the court stated the following in footnote 2 when interpreting Bowling: "We do not read State Farm Mut. Auto. Ins. Co. v. Bowling, 81 So.3d 538 (Fla.Dist.Ct.App.2012) to demand admission of the proposed expert testimony in this case. *Bowling* seems to decide a materially different case. For example, *Bowling* seems to be about, to a significant degree, an argument that the medical services billed did not reflect medical services actually delivered according to the treatment records and *not about mainly a conflict over the reasonableness of charges for medical services, assumed to have been delivered.*" [Emphasis supplied.]

[1] Even with this limited holding, Judge Crenshaw's dissent expressed concern about the possible prejudicial effect of shifting the focus of the trial to the collateral issue of fraud or error by a third party, the health care provider.

Accordingly, there is no case law holding that those, like Mr. Reimer, trained in "medical bill coding" are qualified to testify or permitted to testify to the "reasonableness" of medical charges for medical services in the context of a liability tort claim. In fact, Bowling holds quite to the contrary and is controlling law in Florida. Rather, the current case law limits such testimony to whether medical coding contained in the medical bills was accurate when compared to the medical records of treatment provided. Even then, it must be established that such limited testimony is relevant and that its probative value is not outweighed by the dangers of confusing the issues, misleading the jury, unfair prejudice to Plaintiff, or needless presentation of cumulative evidence.[2] There is certainly no authority that medical coding experts may testify to matters of AMA ethics rules, medical necessity, medical reasonableness, reasonableness of the amount of medical bills to self-pay patients, contract or "letter of protection" interpretation, or construction of any laws or regulations of any kind.

III. Reimer lacks the qualifications to testify on "medical topics" in this case:

The Florida Evidence Code provides the following with regard to the testimony of experts:

> **90.702 Testimony by experts.**—If scientific, technical, or other specialized knowledge will assist the trier of fact in understanding the evidence or in determining a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify about it in the form of an opinion or otherwise, if:
> (1) The testimony is based upon sufficient facts or data;
> (2) The testimony is the product of reliable principles and methods; and
> (3) The witness has applied the principles and methods reliably to the facts of the case.

[2] In addition to the arguments below, Plaintiff submits that any billing code errors can be established by cross examination of treating physicians or health care providers or by direct examination of those physicians' or health care providers' billing department employees. Even if relevant, expert testimony on the topic is cumulative.

In this case, Jeremy Reimer lacks the qualifications to testify on the issues for which his testimony is proffered. He is not a doctor or health care provider of any kind and has never worked for one. He has never worked in the billing department of a doctor, health care provider or hospital. His sole expertise, if he has one, is in medical bill coding, as a "professional billing coder" certified by the American Association of Professional Coders. To the extent his testimony is based upon his interpretation of federal or state laws, such as HIPAA, he is not qualified by skill, training or education to interpret the law. Moreover, the interpretation of such laws is for the Court, not an expert proffered by one party. *See* State Farm Mut. Auto. Ins. Co. v. Physicians Injury Care Center, Inc., Case No. 6:06-cv-1757- ORL-GJK, 2009 WL 6357793, at 21 (M.D. Fla. Jan. 9, 2009)(coding expert not permitted to testify to conclusions of law).

He has not performed any surveys or research on the amounts billed by doctors or other health care providers to "uninsured self-pay" patients like Plaintiff by those in the position of her treating physicians and health care providers, faced with determining a reasonable amount to charge for their services to an individual for whom there are no established and universal guidelines and from whom they will likely collect only on some individualized payment plan or via a letter of protection pertaining to a pending civil claim. Since he is not a medical doctor or health care professional, he lacks the expertise to testify on the "reasonableness" of medical bills in Plaintiff's case or on what charges would be "usual, customary and reasonable" under any definition applicable here. There are no universal standard definitions of what billing is "usual, customary or reasonable" for uninsured, self-pay patients. Rather, each situation is different and

left to the judgment of the health care providers, the charges that are reasonable in the community and the charges that the market in that community will bear.

Since he is not a medical doctor or health care professional, he lacks the expertise to testify on the medical necessity of any of Plaintiff's treatment. For the same reason, he lacks the expertise to testify on medical ethics. Plainly, Mr. Reimer is not qualified by skill, experience, knowledge, training or education to testify on the "medical" topics for which he is offered as an "expert" witness: reasonableness and necessity of medical expenses incurred and medical ethics issues.

IV. Reimer's Testimony Is Not Relevant:

Relevant evidence is defined in Section 90.401, Florida Statutes as "evidence tending to prove or disprove a material fact." Mr. Reimer's testimony does not tend to prove or disprove any material fact in this case.

In a personal injury case, a jury must decide whether an injured plaintiff's medical bills "represent reasonable and necessary medical expenses." *E.g.,* Garrett v. Morris Kirschman & Co., Inc., 336 So. 2d 566, 571 (Fla. 1976). This inquiry is "from the perspective of the injured party, rather than the perspective of the medical expert." Dungan v. Ford , 632 So. 2d 159, 163 (Fla. 1st DCA 1994); *accord* Nason v. Shafanski , 33 So. 3d 117, 122 (Fla. 4th DCA 2010). Accordingly, a plaintiff is not required to provide expert testimony to prove that her medical expenses are reasonable and necessary. Garrett, 336 So. 2d at 571. Instead, this "reasonable and necessary" inquiry focuses on: (1) whether a plaintiff's medical bills "are for treatment the plaintiff sought for injuries at issue in a lawsuit, as opposed to treatment for some other condition, and (2) whether the charges are for a reasonable

amount." Dungan, 632 So. 2d at 163; *accord* Nason , 33 So. 3d at 122; *see also* Fla. Standard Civil Jury Instruction § 501.2 (2010).

Expert "coding" testimony is, at most, marginally probative of what medical expenses are reasonable and necessary. Any probative value is substantially outweighed by the testimony's unfair prejudice, misleading nature, and confusion of the issues. *See §* 90.403, Fla. Stat. (2010). Whether or not a charge is *reimbursable* under federal and state law or under some private health insurance plan or health insurance policy does not tend to prove or disprove a material fact in an automobile accident case, slip and fall case, or personal injury case. That is, it does not tend to prove or disprove whether the charges are "necessary" or "reasonable," as those terms are understood in Florida law. *See* Dungan, 632 So.2d at 163; Nason, 33 So.3d at 122. Whether her treating physicians followed a proper billing code or guideline does not relieve Kelly Garrett of the debt. Even if it did, that dispute is not at issue in this case.

With respect to the "necessary" element, whether a charge is "reimbursable" or not under federal or state law does not tend to prove or disprove whether the charges "are for treatment the plaintiff sought for injuries at issue in a lawsuit, as opposed to treatment for some other condition." *See* Dungan, 632 So. 2d at 163. Similarly, whether a charge is "reimbursable" or not under federal or state law does not tend to prove or disprove whether such charges are for a "reasonable amount." *See* Dungan, 632 So. 2d at 163. This holds true, in fact, for *both* reimbursable and non-reimbursable expenses under some policy of health insurance, even if one were present here. The fact that a provider complied with all federal and state laws on billing, coding, and documentation would not tend to prove or disprove that the providers' charges were necessary or reasonable. Conversely, the fact that a provider

failed to comply with all federal and state laws on billing, coding, and documentation would not tend to prove or disprove that the provider's charges were reasonable or necessary.

Since Mr. Reimer's testimony is based upon billing code standards that pertain to insurance plans or government plans not available to Plaintiff when she incurred her medical expenses, his testimony is irrelevant and does not tend to prove or disprove any material fact, i.e. the reasonableness of the amount of the medical bills she incurred, from *her* perspective. Indeed, he relies entirely upon a database that excludes her precise scenario from the information collected to form its data: medical bills charged to an uninsured self pay patient responsible personally for her own medical and surgical expenses without the benefit of any insurance policy or government medical plan to negotiate group rates and without the personal bargaining power to do anything other than what she did. Mr. Reimer's "coding" analysis is, therefore, irrelevant to a determination of what medical expenses were "reasonable and necessary" as a direct and proximate result of the accident.

Finally, Mr. Reimer's opinion of the amount that is reasonable to charge for services is couched in terms of "usual, customary and reasonable" charges that he has defined using his own formula which is neither peer reviewed nor published anywhere and which is based upon insufficient data, as will be seen below. Mr. Reimer admits wholeheartedly that there are no universally accepted "usual, customary and reasonable" charges for specific medical care in America and that what is "usual, customary and reasonable" varies by payor, e.g. health insurance plans, government health plans, etc. Accordingly, his testimony of what he considers "UCR" charges based upon his own personal "formula" is irrelevant and invades the province of the jury in determining "reasonable and necessary" medical expenses incurred as direct and proximate result of the accident. Mr. Reimer's testimony on "UCR" charges should also be

excluded on grounds of relevancy alone.

V. Reimer's Testimony Is Unduly Prejudicial And Confuses The Issues:

Mr. Reimer's testimony should be excluded on grounds of prejudice or confusion. Section 90.403, Florida Statutes provides as follows:

> **Exclusion on grounds of prejudice or confusion.**—Relevant evidence is inadmissible if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of issues, misleading the jury, or needless presentation of cumulative evidence. This section shall not be construed to mean that evidence of the existence of available third-party benefits is inadmissible.

In a personal injury trial, complex expert "coding" testimony on what charges are "reimbursable" under federal or state law will confuse the issues, mislead the jury, and unfairly prejudice the injured plaintiff. In particular, such testimony will unfairly prejudice an injured plaintiff because it will mislead and confuse the jury into believing that a medical provider's negligence, wrongdoing, or failure to follow purportedly applicable billing and coding requirements precludes the injured plaintiff from recovering as damages her "reasonable and necessary" medical expenses. This result cannot be reconciled with Stuart v. Hertz Corp., 351 So. 2d 703 (Fla. 1977) and its progeny. A medical provider's post-accident medical malpractice and wrongdoing in treating a plaintiff will not relieve the tortfeasor of his liability for a plaintiff s injuries, including any liability for a plaintiff s reasonable and necessary medical expenses. *See* Stuart, 351 So. 2d at 706 (Fla. 1977); Dungan, 632 So. 2d at 162.

The reasoning in Stuart is apropos to this case:

> An active tortfeasor should not be permitted to *confuse and obfuscate* the issue of his liability by forcing the plaintiff to concurrently litigate a complex malpractice suit in order to proceed with a simple personal injury suit… A complete outsider, and a tortfeasor at that, must not be allowed to undermine the patient-physician relationship, nor make the plaintiff s case against the original tortfeasor longer and more complex through the use of a third-party

> practice rule which was adopted for the purpose of expediting and simplifying litigation.
>
> The complex issues of liability to be resolved in a medical malpractice action are foreign to the resolution of liability in the typical personal injury suit. . . .
>
> In summary, to allow a third party action for indemnity [based on medical malpractice] . . . would . . . expand the applicability of the third-party rule and make it a tool whereby the tortfeasor is allowed to complicate the issues to be resolved in a personal injury suit and prolong the litigation through the filing of a third-party malpractice action.

Stuart, 351 So. 2d at 706 (emphasis added).

Stuart prohibited a defendant-tortfeasor in an automobile accident case from impleading the plaintiff s medical provider by way of a third-party claim seeking indemnity based on the provider's alleged malpractice. *Id.* Stuart prohibited this because allowing such a third-party claim "would foreclose the [accident] victim's ability to control the nature and course of the suit." Underwriters at Lloyds v. City of Lauderdale Lakes , 382 So. 2d 702, 704 (Fla. 1980). Later, the First District relied on this rationale from Stuart to hold that evidence of a provider's medical malpractice was inadmissible in an automobile accident case between solely an injured plaintiff and a defendant-tortfeasor. *See* Dungan, 632 So. 2d at 160-63.

Still later, the Fourth District relied on Stuart and its progeny to prohibit evidence and argument that suggested a plaintiff's medical provider had been "unscrupulous" in treating the injured plaintiff with an "unnecessary" surgery. *See* Nason v. Shafanski, 33 So. 3d 117, 118-22 (Fla. 4th DCA 2010). Over the plaintiff's objection, the defendant in Nason argued, based on medical expert testimony, that the plaintiff's provider had recommended and performed an "unnecessary" surgery to treat the plaintiff's injuries from the automobile accident. *Id.* at 119-20. During its deliberations, the jury asked the trial judge the following: "[I]f the jury fe[els] a provider of medical treatment to the plaintiff was *unscrupulous,* does that relieve

the defendant under the law from liability for the consequences of that treatment?" *Id.* (emphasis added). In response, the trial judge declined to give the clarifying instruction requested by the plaintiff, and the jury ultimately awarded less than the plaintiff had claimed for his past medical expenses. *Id.* at 120.

The Fourth District reversed. *Id.* at 122. Relying on Stuart and its progeny, the Fourth District reasoned that the jury's conclusion that the provider was "unscrupulous" showed that the jury had been confused by the defendant's evidence and assertions that the treatment prescribed by the plaintiff's provider (surgery) had been "unnecessary." *Id.* Stated another way, if a plaintiff follows the advice of a competent provider – even one who "unscrupulously" orders "unnecessary" treatment – the plaintiff is still entitled to full compensation for the medical expenses charged by that provider. *See id.* at 121-22. Moreover, the "unnecessary" surgery "unscrupulously" performed by the provider was not "unnecessary" as that term is used in Florida law. To reiterate, whether a medical expense is "necessary" is judged "from the *perspective of the injured party,"* not from the perspective of the defendant's medical expert. *Id.* (emphasis added) (quoting Dungan v. Ford, 632 So. 2d 159, 163 (Fla. 1st DCA 1994).

In a similar vein, in this case, whether Plaintiff's medical expenses are "necessary" must be judged from perspective of the injured person, not from the perspective of a "coding" expert who assists the federal government and insurance companies root out complex fraud perpetuated by medical providers. Admittedly, Stuart and its progeny were cases in which the provider's alleged post-accident wrongdoing involved medical malpractice, whereas in this case and others like it, the tortfeasor defendant is alleging that the provider's post-accident wrongdoing involves improper billing, coding, and outright fraud – essentially, "billing

malpractice." But the principles of Stuart and its progeny should apply with equal force in cases like this one.

The Stuart principles should apply in this case because the alleged wrongdoing – whether it be medical malpractice or billing malpractice – is wrongdoing committed by the plaintiff's *provider,* not by the plaintiff herself. Indeed, one could simply substitute the words "billing malpractice" for "medical malpractice" into the Stuart opinion and easily discern that Stuart' s rationale applies irrespective of the particular wrongdoing by the provider:

> An active tortfeasor should not be permitted to confuse and obfuscate the issue of his liability by forcing the plaintiff to concurrently litigate a complex [billing malpractice] suit in order to proceed with a simple personal injury suit. . . . A complete outsider, and a tortfeasor at that, must not be allowed to undermine the patient-physician relationship, nor make the plaintiff s case against the original tortfeasor longer and more complex through the use of a third-party practice rule which was adopted for the purpose of expediting and simplifying litigation.
>
> The complex issues of liability to be resolved in a [billing malpractice] action are foreign to the resolution of liability in the typical personal injury suit. . . .
>
> In summary, to allow a third party action for indemnity [based on billing malpractice] . . . would . . . expand the applicability of the third-party rule and make it a tool whereby the tortfeasor is allowed to complicate the issues to be resolved in a personal injury suit and prolong the litigation through the filing of a third-party [billing malpractice] action.

Stuart, 351 So. 2d at 706.

The proper forum for resolving any billing fraud, assuming any exists, is a *separate, independent* suit by the tortfeasor against the medical provider who is allegedly billing improperly and committing a fraud. Returning again to the medical malpractice analogy, although a tortfeasor may not raise allegations of medical malpractice in the accident victim's suit against the tortfeasor, the Supreme Court of Florida has held that the tortfeasor may bring a separate, independent subrogation suit against the provider who allegedly commits malpractice. *See* Underwriters at Lloyds v. City of Lauderdale Lakes, 382 So. 2d 702, 704

(Fla. 1980). The supreme court held this because:

> An action brought in subrogation would eliminate the concerns noted in /Stuart/. A subrogation suit is a separate, independent action against a subsequent tortfeasor by the initial tortfeasor. The injured party, having received full compensation for all injuries, is not a party to the litigation and is spared the trauma of an extensive malpractice trial. The initial tortfeasor is simply trying to recoup his losses that in fairness should be shared with a negligent doctor. Under this doctrine the financial burden is equitably apportioned among the responsible parties, and negligent doctors can no longer escape liability for their actions.

Id.

The Supreme Court's rationale in Underwriters also applies in this case involving, essentially, allegations of "billing malpractice" (rather than medical malpractice). The injured party should be spared from having to defend the allegedly improper and fraudulent billing practices of the provider. *See id.* If the initial tortfeasor genuinely believes that the victim's medical provider is engaged in wrongdoing to the detriment of the tortfeasor (i.e., improper billing, coding, etc.), then the tortfeasor (or the representative insurance carrier) should be required to raise those allegations in a separate suit against the provider, not in the victim's personal injury case. *See id.* In such a separate suit, the provider, as a party, can fully defend his or her billing practices; that task should not be left to the provider's patient (the injured accident victim).

Admitting this testimony unnecessarily complicates a garden-variety personal injury case with virtually no probative value. Permitting the admission of expert "coding" testimony transforms a garden-variety accident case into a fraudulent billing case. A trial on fraud opens the door to a wide range of evidence, which complicates and increases the costs of a simple accident trial. As the Supreme Court has noted about fraud in a different context:

> Whenever issues of fraud, and good faith are raised, the evidence must

> take a rather wide range and may embrace all of the facts and circumstances which go to make up the transaction, disclose its true character, explain the acts of the parties, and throw light on their objects and intentions. . . . Where a question of fraud is involved, great latitude is ordinarily permitted in the introduction of evidence.

Adams, 62 So. 2d at 596 (internal ellipses and quotations omitted).

Mr. Reimer's testimony about any improper or inaccurate billing by Plaintiff's treating physicians is similar to the Stuart and Dungan scenarios and should not be admissible as its probative value is outweighed by the propensity for such testimony to confuse the issues and mislead the jury.

Mr. Reimer's testimony about what amounts would be reasonable is based upon his own definition of "usual, customary and reasonable" charges and upon a database of billing information collected by health insurers that necessarily excludes, by definition, billing to uninsured self-pay patients, as was the case with Plaintiff. Requiring Plaintiff and her counsel to cross examine this evasive "expert" to establish the immateriality and irrelevance of his testimony unnecessarily confuses the issues of what health insurers and government health plans define as "usual, customary and reasonable" with what Florida tort law defines as Plaintiff's damages, "reasonable and necessary medical expenses" from *her* perspective.

Any marginally probative value of Mr. Reimer's testimony is plainly and clearly outweighed by the danger of confusion of the issues and misleading of the jury. The issues in this case are whether Plaintiff's medical bills were reasonable and necessary as a result of the accident from the Plaintiff's perspective, not from the perspective of some nonexistent health insurance plan or government medical benefits plan. Evidence that may be relevant to determining whether medical bills were submitted properly from the perspective of some uninvolved health insurer or government plan is not relevant here and confuses the issues and

misleads the jury.

VI. Reimer's testimony serves as a conduit for inadmissible hearsay and his own conclusions of law regarding questions of law that are for the Court:

An expert's testimony may not be used as a conduit for the introduction of otherwise inadmissible evidence. Linn v. Fossum, 946 So. 2d 1032, 1037-38 (Fla. 2006) (internal quotations omitted). Often, a "coding" expert's testimony will serve as such an improper conduit. For example, coding experts may reveal to a jury whether or not an injured plaintiff has private health insurance or government health care benefits *(e.g.,* Medicare, Medicaid, etc.). This testimony should not be allowed under the collateral source rule. *See* Nationwide Mut. Ins. Co. v. Harrell , 53 So. 3d 1084, 1086 (Fla. 1st DCA 2010). In addition, coding experts like Mr. Reimer often base their opinions on various materials prepared by others, such as the Fair Health database and the various billing code manuals and texts referenced in Mr. Reimer's testimony and report. Such testimony should not be allowed because it is merely a conduit for inadmissible hearsay. *See* Linn*,* 946 So. 2d at 1037-38.

Finally, to the extent Mr. Reimer's testimony is based on his interpretation of federal and state laws, such as HIPAA, his testimony constitutes conclusions of law that are questions for the Court, not an expert offered by one party. Indeed, Mr. Reimer admitted he could not comment upon questions of law, such as whether Mrs. Garrett would remain liable to her physicians for any outstanding balance on her medical bills if a jury in her personal injury case was persuaded by his argument to award less than the total amount of the medical expenses charged to her. He simply stated, without any authority whatever, that it was his opinion that she would not be responsible for any "unreasonable" bills as he personally defined them. This topic is not only

outside his field of expertise, as a question of law, but it is a conclusion of law.

"Coding" experts like Mr. Reimer typically opine on what federal and state law requires for billing, coding, and documentation. Coding experts are not licensed attorneys; therefore, they are not permitted to testify on questions of law. *See* State Farm Mut. Auto. Ins. Co. v. Physicians Injury Care Center, Inc., Case No. 6:06-cv-1757- ORL-GJK, 2009 WL 6357793, at *21 (M.D. Fla. Jan. 9, 2009) (instructing another coding expert, Connie Coleman, not to testify as to legal conclusion). It is the trial court's role, not the role of the "coding" expert, to instruct the jury on requirements of federal or state law. *See* Edward J Siebert, A.I.A. v. Bayport Beach and Tennis Club Assoc., Inc., 573 So. 2d 889, 891-92 (Fla. 2d DCA 1990) (holding that it was the duty of trial court to instruct the jury on the meaning of a building code and that it was reversible error to permit experts to opine on how the code should be interpreted).

Mr. Reimer was asked repeatedly in his deposition to cite the law, regulation, or guideline that required application of "medical coding" billing principles to self-pay uninsured patients like Mrs. Garrett. He indignantly insisted that to even question the issue was ridiculous. Yet, on the second day of his deposition, he went on a rambling several page dissertation citing various statutes and regulations that he claimed supported his "opinion" on this issue. Here are just a few examples of the citations. He cited Section 458.323, Fla. Stat. which merely requires medical bills to be itemized and does not mention application of any medical coding principles to determining the reasonableness of charges. He mentioned Section 59E-7.028, F.A.C. that was actually repealed in 2010. He mentioned Section 59B-9.038 which merely pertains to the maintenance of patient records and reporting of data to the Agency for Health Care Administration. Again, that regulation does not appear to address application of medical coding

principles to the determination of the reasonableness of medical charges. He mentioned Section 64B-9.9009 which addresses the standards of care for office surgery. He mentioned Section 64B-8.9091 which pertains to physician licensing and inspections. He also mentioned 45 C.F.R. 162.1002, which he described as part of the Health Insurance and Portability and Accountability Act (HIPAA) as authority for his position. The title of the act itself references health insurance. And 45 C.F.R. 162.1002 is a part of 45 C.F.R. Chapter 162. 45 C.F.R. 162.100 states that this part applies to "covered entities" defined in 45 C.F.R. 160.103 as follows:

> *Covered entity* means:
> **(1)** A health plan.
> **(2)** A health care clearinghouse.
> **(3)** A health care provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter.

(Deposition of Reimer, Volume 2, 122-131).

Clearly, Mr. Reimer is not skilled at interpreting laws and the laws and regulations he cited in support of his methodology come closer to saying the precise opposite and seem to acknowledge that medical coding applies to health insurance plans, not uninsured self pay patients, at least as the pertain to any determination of what charges are "reasonable" for a particular medical service or procedure. He is testifying to conclusions of law that are even incorrect.

The entirety of Mr. Reimer's testimony serves as a conduit for hearsay and comments and personal opinions on questions of law and should be excluded.

VII. Reimer's testimony is based upon insufficient facts or data, based upon unreliable methodology and upon unreliable application of any principles and methods to the facts of the case:

The Florida Evidence Code provides the following with regard to the testimony of experts:

> **90.702 Testimony by experts.**—If scientific, technical, or other specialized knowledge will assist the trier of fact in understanding the evidence or in determining a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify about it in the form of an opinion or otherwise, if:
> (1) The testimony is based upon sufficient facts or data;
> (2) The testimony is the product of reliable principles and methods; and
> (3) The witness has applied the principles and methods reliably to the facts of the case.[3]

Mr. Reimer's opinions are based entirely upon his review of the medical records and bills and comparing the "current procedural technology" (CPT) codes[4] contained in those medical records and bills to the charges for such services as found in the "Fair Health" database he identified in his deposition testimony. He has testified that the "Fair Health" database consists of

---

[3] Previously, 90.702 read as follows: "It scientific, technical or other specialized knowledge will assist the trier of fact in understanding evidence or in determining a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify about it in the form of an opinion, *however, the opinion is admissible only if it can be applied to the evidence at trial*." Plaintiff contends that Mr. Reimer's opinion is inadmissible for all of the same reasons expressed herein, since his testimony cannot be applied to the evidence at trial in this case. Moreover, since it is not established that Mr. Reimer's opinion on determining "reasonableness" of medical expenses is based upon principles that have gained general acceptance in his own field of expertise. See Frye.

[4] According to the American Medical Association website, CPT is a registered trademark of the AMA and is the most widely accepted medical nomenclature used to report medical procedures and services ***under private and public health insurance programs***. *See http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt.page?*. Of course, Mrs. Garrett is uninsured and is neither herself a private health insurance program, nor a public health insurance program, nor was she eligible for payment by any such programs when her accident related charges were incurred. While Mr. Reimer went on for pages in his deposition citing statutes and regulations that he contended required application of CPT coding to a determination or reasonable charges for uninsured self-pay patients, Plaintiff submits none of those laws prescribed such was the case and, in any event, the interpretation of laws and regulations are questions of law for the Court, not Mr. Reimer.

medical billing data provided only by health insurers, not by doctors or patients. Necessarily and by definition, the "Fair Health" data would not have included billing data from physicians and patients in the precise position and circumstances of Plaintiff: medical bills submitted by physicians, surgeons and health care providers to ***uninsured self pay patients ineligible for any private health insurance or government health plan reimbursements to pay their medical bills***. In fact, such data would have been systemically *excluded* from the "Fair Health" database by very design of the database and the very source of its data.

Mr. Reimer's testimony is, therefore, based upon insufficient facts and data to be applied to Mrs. Garrett's case. It is also unreliable in that his very methodology is to apply such insufficient facts and data to a case that itself would have been excluded from the data relied upon, i.e. the "Fair Health" database. Mr. Reimer, to use an "old saw", is comparing "apples to oranges" and drawing completely unreliable conclusions based upon entirely insufficient and inapplicable facts and data. His testimony should be excluded.

Yet, there is more. Mr. Reimer describes his analysis as a two step process whereby after making his CPT code analysis and identifying any "fraud", errors, impermissible "unbundling", impermissible "upcoding" and the like, he then determines by reference to the Fair Health database the 25th, 50th, 75th and 90th percentiles of charges for the same services as found in the Fair Health database and concludes that the highest charges that *he* considers "usual, customary and reasonable" (UCR) is at the 75th percentile of the charges found in the database.[5] He admits that his "personal formula" for UCR is not peer reviewed or published. Accordingly, his testimony on UCR is "pure opinion" prohibited by Daubert and lacking the foundational

[5] As mentioned previously, the database by design excluded data from medical billing of uninsured self pay patients, as is the case with Mrs. Garrett and a host of other uninsured Americans.

principles of any industry to satisfy a Frye analysis, as well. He simply has pulled this "formula" out of his own hat. The fact is that the "Fair Health" database itself contains billing from health care providers ranging from the 1st percentile on the low end of the billing range to the 100th % on the high end of the billing range *for services as billed to health insurers*, by his own admission and by definition. One could take the position that the entire range from the 1st through the 100th percentiles establish "UCR" ranges for "bills submitted to health insurers". Mr. Reimer lacks any authority to pull a "magic formula" from his hat and conclude *ipso facto* that the only reasonable billing range is from the 25th to the 75th percentiles of the billing data collected from health insurers by Fair Health. Moreover, as mentioned previously, Fair Health excludes by design and by definition billing data concerning the uninsured population, such as Mrs. Garrett. His analysis, therefore, has no application to Mrs. Garrett's particular medical billing situation in any event.

Since Mr. Reimer's testimony is based upon insufficient facts and data, is based upon a formula that is neither peer reviewed nor published, is based upon data that excludes the very factors present in Mrs. Garrett's circumstances, is the product of an unreliable methodology, and does not apply relevant principles and methods to the facts of the case, his testimony should be excluded under Section 90.702, Fla. Stat.

VIII. Reimer's testimony is really being offered in an attempt to engage in "character assassination" of Plaintiff, her counsel and her treating physician(s):

Defendant is really offering this "expert" testimony as a part of a long standing trial strategy in this case to engage in "character assassination" of Plaintiff, her counsel and her treating physicians. First, let us address the current attempt to engage in "character

assassination" of her physicians. The real reason Defendant is proffering the testimony of this billing code expert is to suggest by innuendo or overtly that the treating physicians are "in cahoots" with Plaintiff and her counsel to defraud and take advantage of the Defendant and that the physicians are unethical. The content of Mr. Reimer's own website (www.medicalcodingreview.com) makes clear that it is his intention to malign injured plaintiffs, their counsel and their physicians. Mr. Reimer admitted in deposition testimony to the content of his website and the fact the *he wrote* the content on his website. The website refers to physicians in personal injury cases as "tricksters", accuses them of "fraud and falsification" resulting in unnecessary treatments or procedures. His website contains statements such as the following:

- "Personal injury cases bring out the worst in people—as claimants, attorneys, and even physicians are getting in on the act."
- "Bogus billing is a big problem in personal injury cases, and it is getting worse."
- "Unscrupulous physicians may seize the opportunity to submit exaggerated bills."
- "There are several ways that unethical medical providers falsify bills for personal injury suits."
- "First, these violations work to fraudulently inflate the patient's medical bills. Coding violations also falsify the patient's injuries to support treatments that have been (inappropriately) rendered."

It is also obvious that Mr. Reimer fully intends for his "expertise" and testimony to be used to persuade juries to question the entire case, not just the medical bills. Indeed, it appears

the strategy he envisions in offering his testimony is to distract, confuse and mislead juries in personal injury cases, based upon statements such as the following:

- "By challenging the medical coding and billing in personal injury cases, defense attorneys can persuade the jury to not only question the validity of the bills generated by the medical providers, **but also the validity of the claimant's case in general**."
- "By challenging a physician's coding, defense attorneys can get the jury to question the validity of the bills generated by the physician."

(Deposition of Reimer, Volume 2, Pages 198-214).

Mr. Reimer contends under oath in his deposition that it is customary for the guidelines and standards applied via medical coding principles to define "usual, customary, and reasonable" billing in the first party health insurance industry to be also applied to personal injury liability claims; however, it is clear from his website that he knows this is not the case. It is clear from his own website that he knows that the medical coding, CPT coding, guidelines, data and standards he relies upon in reaching his conclusions do not, in fact, apply to the scenario of an uninsured self pay personal injury claimant. In fact, his own website clearly indicates that the purpose of his expert witness services is to "force" application of medical coding principles and health insurance contract and government health plan billing practices and standards to personal injury liability claims involving uninsured plaintiffs with no health insurance or government health plans. Let's review a few of his statements from his website:

- "Personal injury cases seem to operate on their own set of rules (or lack thereof), especially when it comes to medical coding and billing. In a traditional healthcare setting, HMO's and insurance carriers

scrutinize every charge submitted for payment. When charges do not conform to proper coding standards, they are rejected in their entirety. It is then up to the provider to correct the errors and resubmit the bills for payment."

- "In contrast, auto insurers and other self-insured parties involved in personal injury cases often have little recourse in disputing charges submitted by a claimant's medical providers. The tables are turned, and it is up to the defense to disprove the validity of a plaintiff's medical bills."
- "Unlike health insurance companies—which scrutinize every bill submitted for payment---auto insurance companies and self insured carriers often have little recourse to dispute medical charges."

(Deposition of Reimer, Volume 2, Pages 198-214).

Of course, Mr. Reimer would not admit during his deposition that he considered it his role or purpose in personal injury litigation to convince courts and juries to apply medical coding principles used in reducing medical billing in the private and public health insurance industries to personal injury cases of uninsured injured plaintiffs. The above statements in his website belie his testimony under oath. Clearly, that is precisely his goal…to convince jurors to apply medical coding principles to personal injury cases involving uninsured self-pay patients. If Mr. Reimer really believes that the coding standards and guidelines he relies upon apply with equal force to both "liability claims" and to "first party" health insurance billing, where group rates and managed health care agreements are designed to allow for negotiated rates and terms of reimbursement, why would he makes statements such as those above on his website? Why

would his services be needed at all? He knows full well that he is taking the complex health insurance medical coding, billing standards, guidelines and regulations applicable to the review of medical billing in private and government health insurance plans, which are themselves not uniform even in the health insurance industry, and applying them where they do not belong---for consideration by a jury in determining damages in a liability case where no such health insurance contract or government health plan is in play. Indeed, he admits that there is no uniform "UCR" applicable across the board to medical billing. This is why he had to invent his own "formula" for use in his testimony in tort litigation.

There is no evidence that Plaintiff, her counsel, or her treating physicians have engaged in any kind of conspiracy to defraud Defendant, inflate medical charges, or take advantage of anything, nor is there any evidence that the treating physician(s) are unethical, even assuming Mr. Reimer has the qualifications required by law to speak upon such topics. The fact is that Plaintiff was uninsured when injured, was fortunate enough to have been referred to Dr. Masson by other physicians so she could get any treatment at all via a letter of protection, and was then blessed to have Dr. Masson open his own surgery center in 2014 which allowed him to perform cervical disc surgery upon her via letter of protection, something that he could not do until 2014 because hospitals do not accept letters of protection. For Defendants to be permitted to cast aspersions toward Dr. Masson, Plaintiff or her counsel, with innuendo and suggestions of fraudulent billing, unnecessary treatment and surgery, and unethical conduct would be a travesty. The only way for Plaintiff to combat such a defense strategy would be a virtual "free for all" trial of character evidence and admission of otherwise inadmissible issues such as Medicaid applications, Plaintiff's financial condition, collateral source evidence, and rebuttal "good character" evidence among only a few.

It is improper to accuse Plaintiff's medical experts of perjury, or accuse Plaintiff's counsel of fraud or unethical conduct. Venning v. Roe, 616 So.2d. 604 (Fla. 2d DCA 1993); Kaas v. Atlas Chemical Company, 623 So.2d. 525 (Fla. 3rd DCA 1993); Stokes v. Wet 'N Wild, Inc., supra., 523 So.2d. 181 (Fla. 5th DCA 1988) and Sacred Heart Hospital of Pensacola v. Stone, supra. Overtly or by innuendo, that is precisely what Defendant seeks to do in this case.

Degrading or humiliating the plaintiff or opposing counsel by referring to them as "greedy," or "liars," or demeaning "plaintiff's lawyers" is improper. See Ryan v. State, 457 So.2d 1084 (Fla. 4th DCA 1984); Kendall Skating Centers v. Martin, 448 So.2d 1137 (Fla. 3d DCA 1984); Hartford Acc. and Indem. Co. v. Ocha, 472 So.2d 1338 (Fla. 4th DCA 1985); and Clay v. Thomas, 363 So.2d 588 (Fla. 4th DCA 1978). Whether overtly or by innuendo, this is precisely what Defendant seeks to do in this case.

During discovery in this case, Defendant has blanketed Plaintiff's neighborhood with deposition subpoenas and deposed neighbors, most of whom ultimately admitted they were only familiar enough with Plaintiff to know who she is and see her going in and out of her home. Most of these neighbors also were surprised that they had been subpoenaed to testify about a person of whom they really knew little and in a lawsuit about which they knew nothing. This was humiliating and embarrassing to Plaintiff and her family and effectively ostracized her in her own community. One subpoenaed neighbor "witness" complained that visitors to Plaintiff's teenage children damaged his mailbox and lawn and generally provided disparaging but unfounded "character" testimony regarding Plaintiff being dishonest, etc.. Defendants also dug up one old acquaintance in Gainesville, Florida who had sued Plaintiff in small claims court over an alleged debt arising from the friend's offer to charge emergency veterinary care for Plaintiff's pet on the friend's credit card. Defendant deposed this friend whose testimony on

injuries/physical capabilities of Plaintiff was so limited that it was laughable that Defendant would have spent the time and expense of deposing the friend.

The courts have roundly condemned efforts to win a case by smearing the opponent. See, e.g., Garcia v. Konckier, 771 So.2d 550 (Fla. 3d DCA 2000); Smith v. Hooligan's Pub & Oyster Bar, Ltd., 753 So.2d 596 (Fla. 3d DCA 2000); See also, Stripling v. State, 349 So.2d 187 (Fla. 3rd DCA 1977); and Thigpen v. United Parcel Services, Inc., 990 So.2d 639 (Fla. 4th DCA 2008). A witness may not be impeached with prior bad acts, for example, even if any of the evidence from these witnesses are considered "bad acts." See, e.g., Williams v. State, 324 So.2d 672 (Fla. 4th DCA 1975) (error to impeach defendant with prior arrests and criminal charges); New England Oyster House v. Yuhas, 294 So.2d 99 (Fla. 3d DCA 1974) (trial court properly refused to allow defense to impeach plaintiff with statement in deposition that she lied on her income tax). In Dempsey v. Shell Oil Co., 589 So.2d 373 (Fla. 4th DCA 1991), the court reversed because of improper admission of evidence about the plaintiff's employment history. The plaintiff, who had dropped his claim for lost earnings, had stated in deposition that he had never been fired, and the defense presented testimony from a former employer that he had, in fact, been fired. The court held that this was improper impeachment on a collateral issue.

Pursuant to section 90.404, Florida Statutes "[e]vidence of a person's character or a trait of character is inadmissible to prove action in conformity with it on a particular occasion," and evidence of the witness's character for truthfulness or untruthfulness by evidence of specific acts is not authorized by sections 90.608 and 90.609, Florida Statutes (2012), Pantoja v. State, 990 So. 2d 626, 629 (Fla. 1st DCA 2008). Personal disputes and opinions of former friends or neighbors should not be heard at this trial.

Here, the defense may try to use evidence of past personal disputes with former friends

and neighbors to cast Plaintiff in a negative light in front of the jury. The witnesses will be put on the stand to purportedly testify to some extremely limited knowledge of Plaintiff's activities and physical abilities, which are minimally harmful, if harmful, to her personal injury claim, leaving Plaintiff's counsel to be required to impeach these witnesses with evidence of personal disputes leading to personal biases and vendettas against Plaintiff. These sideshows have nothing to do with Plaintiff's injury or her damages. This Court should not allow these witnesses to testify at all since the probative value of their testimony, if probative at all, is outweighed by the unfair prejudice caused by requiring Plaintiff's counsel to raise these personal dispute issues as impeachment of their credibility and biases against Plaintiff. §90.403, Florida Statutes.

In this case, the Defendants' counsel has even deposed a boyfriend/fiancée and asked, how soon after they met the two had sexual intercourse. Specifically, the question was as follows:

"All right. So let me ask you this: How soon after you and Mrs. Garrett started dating, the two of you began to have sexual relations?"

This was after lengthy questioning of whether he was supporting her financially and how she supported herself. Plaintiff submits these were also improper areas of inquiry.

Now, Defendants seek to disparage Plaintiff's treating physicians with innuendo of improper billing, false billing, and even fraud. Apparently, the aim is to paint Plaintiff as a promiscuous and dishonest "welfare queen" who is now "gaming" the civil justice system along with her "unethical" and "fraudulent" doctors and her crafty lawyers. The suggestion of any of this highly prejudicial and immaterial contentions, whether overtly, with subtlety or by innuendo, is not only reprehensible, but it creates reversible error at any trial of this case since all of that evidence would be inadmissible and improper "character assassination" evidence.

Plaintiff fully intends to submit separate motions *in limine* on all these separate and specific topics, but only mentions them here to demonstrate to the Court that it has become abundantly clear that the trial strategy of Defendant is to engage in a "character assassination" of Plaintiff, her physicians, and by extension her counsel and to make this innuendo a *feature* at trial in their desperate effort to defeat Plaintiff's claims for significant damages leading to one surgery and another recommended surgery. This is apparently being done to distract the jury from the real issues of liability and damages arising from the accident that is the subject of this lawsuit because Defendant is on the losing end of the real issues. This strategy should not be permitted and should be halted in its tracks by order *in limine*. The Court should start here by excluding the testimony of Mr. Reimer in its entirety.

WHEREFORE, Plaintiff, KELLY GARRETT, moves this Honorable Court for an order *in limine* excluding the testimony of Defendant's, ALBERTSON'S, LLC, billing code expert, Jeremy Reimer, entirely. Alternatively, at the very most, Mr. Reimer's testimony should be limited, as suggested in Bowling, strictly to whether or not CPT coding in the medical bills submitted to Mrs. Garrett were accurate compared to the treatment documented in the medical records. Mr. Reimer should ***not*** be permitted to testify on any of the following topics:

1. Medical necessity;
2. Medical reasonableness;
3. Reasonableness of medical expenses;
4. UCR (usual, customary and reasonable amounts for medical services or procedures);
5. Medical ethics;
6. AMA ethics rules or codes or requirements, including but not limited to

whether any care or treatment constituted a "physician self-referral" or whether any billing constituted prohibited "contingent fee" billing;

7. Fraud;
8. Falsification of billing;
9. "Trickster" physicians or health care providers;
10. "Bundling" or "unbundling" of charges;
11. "Upcoding";
12. Whether certain treatment was appropriate under DHHS or other medical or government laws, regulations, or guidelines, including whether Mrs. Garrett's surgery was permissible "outpatient" versus "inpatient" surgery;
13. Whether care and treatment was in violation of any federal or state statutes or administrative codes or regulations;
14. Whether Mrs. Garrett is or is not "legally liable" or "responsible" for any particular billing;
15. Whether any particular bill is "not owed" by Mrs. Garrett;
16. Whether any particular bill is or may be "disallowed";
17. The "reasonable" amount to place on the monetary value any particular medical service, treatment or procedure provided to Mrs. Garrett.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished, by electronic service, this _____ day of _____, 2014, to: A. Craig Cameron, Esquire, Cameron, Hodges, Coleman, LaPointe & Wright, P.A., 111 N. Magnolia Avenue, Ste. 1350, Orlando, FL 32801 serviceACC@cameronhodges.com.

Melvin B. Wright, Esq.
FBN 559857
Colling Gilbert Wright & Carter, LLC
The Florida Firm
801 N. Orange Ave., Suite 830
Orlando, FL 32801
Telephone: (407) 712-7300
Facsimile: (407) 712-7301
Attorneys for Plaintiff
Primary: mwright@thefloridafirm.com
Secondary: brivera@thefloridafirm.com