[Cite as *King v. Promedica Health Sys., Inc.*, 2010-Ohio-2578.]

IN THE COURT OF APPEALS OF OHIO
SIXTH APPELLATE DISTRICT
LUCAS COUNTY

Virginia King	Court of Appeals No. L-09-1282
Appellant	Trial Court No. CI 200903599
v.	
ProMedica Health System, Inc., et al.	**DECISION AND JUDGMENT**
Appellees	Decided: June 4, 2010

* * * * *

John Murray, Leslie Murray, Michael Stewart, and John Huffman, for appellant.

Marshall Bennett, Jr., Jennifer Dawson, and John Borell, Jr., for appellees.

* * * * *

OSOWIK, P.J.

{¶ 1} This is an appeal from a judgment of the Lucas County Court of Common Pleas which granted appellees' motion to dismiss appellant's complaint pursuant to Civ.R. 12(B)(6). For the reasons set forth below, this court reverses the judgment of the trial court.

{¶ 2} Appellant, Virginia King, sets forth the following sole assignment of error:

{¶ 3} "I. The trial court erred by dismissing a patient's complaint against a health care provider that circumvented its contractual and statutory obligation to seek compensation for covered services solely from the patient's health insurer by directly billing her automobile insurer for an inflated amount."

{¶ 4} The following undisputed facts are relevant to the issues raised on appeal. Following injuries sustained in a motor vehicle accident, appellant received medical treatment at the Toledo Hospital. Appellant was covered by an Aetna health insurance plan pursuant to which appellee was a preferred provider.

{¶ 5} Given the preferred provider contract in place between appellant's healthcare insurer and the healthcare provider from whom treatment was received, the billing activities in connection to the treatment were subject to the statutory limitations established by R.C. 1751.60(A). The crux of R.C. 1751.60(A) is that in preferred provider scenarios, compensation, and therefore billing, may solely be pursued from the contracting health insurer.

{¶ 6} Despite the contractual arrangement between the parties and its statutory implications pertaining to billing exclusivity, appellees directly billed appellant's motor vehicle insurer rather than the contracting healthcare insurer with whom appellant was a subscriber. We note that although there is much discussion regarding the pecuniary motivations potentially underlying this billing strategy, that issue is not relevant to the statutory interpretation nature of this appeal.

{¶ 7} On November 5, 2008, appellant filed a complaint in the United States District Court. On March 24, 2009, appellant voluntarily dismissed the federal action. On April 13, 2009, appellant refiled the matter in state court. On June 10, 2009, appellees filed for dismissal of the matter pursuant to Civ.R. 12(B)(6). On October 1, 2009, the motion to dismiss was granted. The instant appeal ensued.

{¶ 8} In her sole assignment of error, appellant asserts that the trial court erred in granting the Civ.R. 12(B)(6) dismissal. In support, appellant determinatively relies upon the notion that the disputed trial court judgment was premised upon a flawed interpretation of R.C. 1751.60(A). In essence, appellant maintains that R.C. 1751.60(A) prohibits appellees from billing anyone other than her health insurer for the treatment rendered to her, while appellees conversely contend that the statute only prohibits billing appellant herself, but does not prohibit invoicing potential third-party payors, such as the motor vehicle insurer.

{¶ 9} It is well-established that appellate review of a disputed Civ.R. 12(B)(6) judgment is conducted pursuant to an independent, de novo standard of review. *Perrysburg Twp. v. Rossford*, 103 Ohio St.3d 79, 2004-Ohio-4362, ¶ 5.

{¶ 10} R.C. 1751.60(A) establishes in pertinent part, "every provider or health care facility that contracts with a health insurance corporation to provide health care services to the health insurance corporation's enrollees or subscribers shall seek compensation for covered services solely from the health insurance corporation and not, under any

circumstances, from the enrollees or subscribers, except for approved copayments and deductibles."

{¶ 11} In a strikingly similar case assessing this precise issue, the Eleventh District Court of Appeals held in relevant part, "Here, appellee billed and accepted $2,566.06 more than it was entitled to from Nationwide in violation of R.C. 1751.60. Under the statute, appellee was required to seek compensation for covered services solely from Anthem and was only permitted to seek approved co-payments and deductibles from Nationwide." *Hayberg v. Physicians Emergency Serv. Inc.*, 11th Dist. No. 08-P-0010, 2008-Ohio-6180, ¶ 26.

{¶ 12} Likewise, the present case is rooted in the existence of a preferred provider agreement. In this case, the underlying agreement was between Aetna and ProMedica. The key, determinative word utilized in R.C. 1751.60(A) is "solely." The commonly understood meaning of the term is reflected in the definition set forth in Black's Law Dictionary (6 Ed. 1991) which defines sole as, "Without another or others." In applying that unambiguous term to the instant case, we find that the term "solely" clearly and plainly means to the exclusion of others.

{¶ 13} Based upon the foregoing, the plain and unambiguous meaning of R.C. 1751.60(A) is that health care providers and facilities who execute preferred provider agreements with health insurance corporations can solely bill the health insurance corporation subject to the agreement for covered services furnished to enrollees or subscribers covered by the agreement to the exclusion of any and all other potential

payors. As such, we interpret R.C. 1751.60(A) consistent with *Hayberg* and contrary to the mistaken, non-exclusive payor interpretation proffered by appellees.

{¶ 14} We have carefully reviewed and considered the record of evidence in this matter. We find that appellees were statutorily prohibited from billing appellant's motor vehicle insurer for the medical treatment rendered to her at the Toledo Hospital pursuant to the plain and unambiguous meaning of R.C. 1751.60(A). Wherefore, we find appellant's sole assignment of error well- taken.

{¶ 15} On consideration whereof, the judgment of the Lucas County Court of Common Pleas is reversed. Appellees are ordered to pay the cost of this appeal pursuant to App.R. 24.

JUDGMENT REVERSED.

A certified copy of this entry shall constitute the mandate pursuant to App.R. 27. See, also, 6th Dist.Loc.App.R. 4.

Peter M. Handwork, J. _____
JUDGE

Mark L. Pietrykowski, J. _____
JUDGE

Thomas J. Osowik, P.J. _____
CONCUR.
JUDGE