NO. 97228-1
[Court of Appeals No. 77578-2-I]

SUPREME COURT OF THE STATE OF WASHINGTON

PAUL HAMAKER, individually and as a putative class representative, and JOSEPHINE HAMAKER, individually and as a putative class representative,

Respondents,

v.

HIGHLINE MEDICAL CENTER, a Washington non-profit corporation;

Petitioner,

REBECCA A. ROHLKE, individually, on behalf of the marital community and as agent of non-party Hunter Donaldson; JOHN DOE ROHLKE, on behalf of the marital community; RALPH WADSWORTH, individually, on behalf of the marital community, and as agent of non-party Hunter Donaldson, JANE DOE WADSWORTH, on behalf of the marital community; TIM CARDA, individually, on behalf of the marital community, and as agent of non-party Hunter Donaldson, JANE DOE CARDA, on behalf of the marital community; GRACIELA PULIDO, individually, on behalf of the marital community and as agent of non-party Hunter Donaldson, JOHN DOE PULIDO, on behalf of the marital community, KIMBERLY WADSWORTH, individually, on behalf of the marital community and as agent of non-party Hunter Donaldson, and JOHN DOE WADSWORTH, on behalf of the marital community,

Defendants.

PETITION FOR REVIEW

Jennifer D. Koh, WSBA #25464
Caitlyn Y. Portz, WSBA #51437
Attorneys for Petitioner Highline Med. Ctr.
FAIN ANDERSON VANDERHOEF ROSENDAHL O'HALLORAN SPILLANE, PLLC
701 Fifth Avenue, Suite 4750
Seattle, WA 98104
206.749.0094

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I. IDENTITY OF PETITIONER

Petitioner Highline Medical Center submits this Petition for Review.

II. COURT OF APPEALS DECISION

In its March 25, 2019 unpublished decision, Division I reversed the trial court's summary judgment order dismissing Paul and Josephine Hamaker's claims of negligence, fraud, unjust enrichment, and violations of the Consumer Protection Act (CPA), based on Highline Medical Center's lawful assertion of a claim to medical lien under RCW 60.44.010. *Slip Op.* at 13. The Court of Appeals concluded that the Hamakers raised cognizable claims by alleging that Highline filed notices of lien claim *before* billing them directly, thereby "depriv[ing] them of the choice to have their health insurer pay for the fees" and "forc[ing] them to pay Highline out of their [personal injury lawsuit] settlement." *Id.* at 2, 10-13. Without independent analysis, the Court of Appeals also reversed the trial court's orders denying the Hamakers' motions for declaratory relief regarding the "validity" of the medical liens for which Highline never sought enforcement, for injunctive relief in the form of the recorded lien releases not required by statute, and for class certification. *Id*. at 13. Highline filed a motion for reconsideration on April 15, 2019; the Court of Appeals denied reconsideration on April 19.

Because the decision of the Court of Appeals (1) ignores the Hamakers' admitted debt and their responsibility for their own voluntary

choices; (2) eviscerates the whole concept of standing by accepting as actionable allegations of injury that resulted directly from the Hamakers' voluntary choices and have no connection to any act or omission by Highline in violation of any contractual, statutory, or common law duty; and (3) vastly expands the potential liability faced by medical services providers who attempt to take a advantage of their statutory right to assert medical lien claims such that the Supreme Court should determine the case as a matter substantial public interest, review should be accepted under RAP 13.4(b)(1), (2), and (4).

III. ISSUES PRESENTED FOR REVIEW

1. Should this Court grant review because the decision of the Court of Appeals conflicts with Washington law holding that voluntary payment of an admitted debt, without more, is not an actionable injury?

2. Should this Court grant review because the decision of the Court of Appeals conflicts with Washington law applicable to the debtor-creditor relationship between the Hamakers and Highline Medical Center?

3. Should this Court grant review because the decision of the Court of Appeals so conflicts with the plain language of Chapter 60.44 RCW and exposes medical care providers to the risk of liability far beyond their contractual, statutory, and common law duties that it raises issues of substantial public interest that should be determined by the Supreme Court?

IV. STATEMENT OF THE CASE

A. Factual Background.

On May 30, 2012, Paul and Josephine Hamaker appeared at the emergency department at Highline Medical Center, complaining of injuries suffered during a motor vehicle accident. CP 653, 657. Highline's nurses and other health care providers in the emergency department provided medical care to the Hamakers. CP 653-60. They were both conscious and able to consent to receiving healthcare and to provide details of the accident and their injuries, as well as their personal information, such as their identities, contact information, and insurance information. CP 283:24-284:2, 455-56, 653-60. As they had not been to Highline in the past, Highline personnel had to rely on the Hamakers to provide any and all such information to be used for billing purposes. CP 456, 951:18-20. Although they provided personal information and contact information for billing purposes when requested by Highline personnel, the Hamakers *voluntarily chose not to identify their insurers*, agreeing instead to entry of "self pay" as their insurance on Highline's records. CP 456, 951:13-17.

On June 7, 2012, Highline Emergency Physicians, PLLC, issued a billing statement to Josephine Hamaker for a charge of $542.85 for care provided by Douglas Birkebak, PA, at Highline on May 30, 2012. CP 450.

On June 12, 2012, Hunter Donaldson, LLC, (hereinafter "HD"),

Highline's independent contractor, sent a letter to the Hamakers identifying itself as managing "the accident claims process for Highline Medical Center," acknowledged that the Hamakers "may have been involved in an accident," and asking for "information about other insurance, ***yours*** or the other party's." CP 665 (emphasis added); *see also* CP 619:18-620:3. In response, Mr. Hamaker stated that their car was "struck from behind by a vehicle operated by Stephanie Nielsen"; as to insurance information, he identified only Ms. Neilsen's insurer, American Commerce. CP 665.

On July 2, 2012, HD recorded notices of claim of medical liens with the King County Auditor's Office, pursuant to Chapter 60.44 RCW. CP 667-68. Without identifying any amount, the notices state that Highline (1) "provided medical care, items and/or services" to the Hamakers, "which were necessary because of injuries allegedly caused by" "American Commerce Insured," and (2) "claims a lien for a reasonable value of the medical care, items and/or services provided." *Id.* The notices list addresses for Highline, the Hamakers, and American Insurance. *Id*.

On July 10, 2012, Highline Emergency Physicians, PLLC, issued a billing statement, noted as "31-60 DAYS" after the service date of May 30, 2012, to Paul Hamaker for a charge of $542.85. CP 449.

After learning about the lien notices, Mr. Hamaker called HD on January 15, 2013; a representative informed him that the liens were asserted

against the third party insurer. CP 760. When Mr. Hamaker claimed he had already paid charges of "500+" "out-of-pocket," the representative confirmed that no payments had been received by HD or Highline Medical Center and told him the amounts of the outstanding hospital charges. *Id*.

On May 31, 2013, HD recorded new notices of claim, including the same information as the notices recorded in July 2012. CP 690-61. On April 29, 2014, HD sent letters to Christopher Williams, the Hamakers' personal injury attorney, providing notice that Highline "claims a lien on any damages that [the Hamakers] may recover," pursuant to RCW 60.44.010, and requesting that he "please contact us for the final lien amount as we may have received payments from other sources, thereby reducing the total outstanding balance." CP 452, 454. On May 8, 2014, HD recorded new notices of claim, including the same information as the notices recorded in May 2013 and July 2012. CP 693-94. On June 26, 2014, HD sent its final correspondence to Mr. Williams, stating that it was "withdrawing our lien for medical services." CP 696-97.

On July 20, 2014, Highline Medical Center issued a statement listing total charges of $833 for services provided on May 30, 2012 to each of the Hamakers. CP 464-466. On July 28, 2014, Mr. Williams sent a letter to American Commerce including in a list of medical expenses two charges of $833 for "Highline ER" on "5/30/12." CP 699-701. In an email to Mr.

Williams on August 13, 2014, Mr. Hamaker acknowledged that the "recent bills we received from Highline Medical Center totaling $1,666," influenced his decision to reject American Commerce's initial settlement offer. CP 703. On April 20, 2015, after settling their individual personal injury claims for $8,343.43 and $8,000 respectively, the Hamakers directed Mr. Williams to "pay to Highline medical center $1110.72 for our medical bill," based on a reduction "pursuant to Mahler." CP 710.

On May 27, 2015, Highline received $1110.72 from Mr. Williams, wrote off the remaining balance of $555.28 between the two accounts, and never attempted further collection from the Hamakers. CP 625.

B. Procedural Background.

In their complaint, the Hamakers' theory was that false statements on the notarization by Rebecca Rohlke on the notices of claim filed on July 2, 2012 rendered "invalid" any future claim for payment by HD or Highline. CP 11-12, 20-23, 25-29. Highline challenged the Hamakers' standing to assert legal claims based on their theory of the "invalidity" of the notices of lien filed by HD pursuant to the provisions of former Chapter 60.44 RCW. CP 589, 597-99. Importantly, as relevant to the question of standing, Highline argued that the Hamakers could not identify a genuine issue of material fact as to any injury they sustained as a result of any action or omission by Highline because there was no evidence that they paid any

amount to Highline beyond what they admittedly owed to Highline for the medical services Highline provided to them on May 30, 2012; the Hamakers did not dispute that they owed Highline at total of $1666, that those charges were reasonable, and that they paid Highline only $1,110.72. CP 605-06.

To support their various theories of injury, the Hamakers claimed, based on Mr. Hamaker's deposition testimony, that they were each charged $542 by Highline Medical Center when they were at the hospital and used a credit card to make payments. CP 419:1-17. However, the only evidence the Hamakers presented to the trial court to support that testimony actually contradicted it: the statements showing charges of $542 for each of the Hamakers for medical services provided on May 30, 2012 were issued by Highline Emergency Physicians, PLLC, an entity with a different name and a different mailing address, not Highline Medical Center. CP 283, 424, 449-50; *compare with* CP 466, 464. Other evidence established that Highline Medical Center only charged the Hamakers $833 each, for a total of $1,666, for the care provided by the hospital – that is, the "facility charges" – and that the only payment ever received by Highline was $1,110.72 on May 27, 2015. CP 464, 466, 624:15-16, 625:17-19, 628-29, 760. In other words, the evidence presented to the trial court established that Highline Medical Center had no role whatsoever in the billing and/or collection of the $542 in fees paid by the Hamakers to Highline Emergency Physicians, PLLC,

regardless of when the actual payment was made or received.

As to the Hamakers' claims regarding their personal health insurance, Mr. Hamaker admitted that they *chose* not provide any insurance information to Highline Medical Center when they received medical services on May 30, 2012. CP 419:16-17, 420:4-8. The Hamakers also produced a copy of Mr. Hamaker's consent to treat form. CP 283:23-284:2, 455-56. Although the copy presented to the trial court is unsigned and large portions of the text are obstructed by a post-it note, Mr. Hamaker did not dispute before the trial court that he provided the personal information typed into the form at the request of Highline Medical Center personnel on May 30, 2012, that he did not provide insurance information when requested such that the box labeled "INSURANCE" includes the phrase "SELF PAY," and that he received a copy of the form and therefore understood that Highline did not have any way to bill his insurer as of May 30, 2012. *Id.* Similarly, the Hamakers did not dispute that the form includes, among other things, paragraphs labeled "CONSENT TO MEDICAL CARE," RELEASE OF PATIENT INFORM[ATION]," "ASSIGNMENT OF INSURANCE B[ENEFITS]," "FINANCIAL AGREEMENT," and "CHARITY CARE PROGRAM." CP 456. The Hamakers did not contend that Highline acted in any way that was inconsistent with the information provided on that form with regard to billing.

As to communications from HD or Highline between May 30, 2012 and May 27, 2015, the Hamakers did not identify any false, misleading, or coercive statements that could have deceived an average member of the public. To the extent the Hamakers claimed to believe that a medical lien under Chapter 60.44 RCW could be asserted against their house, they failed to identify any evidence suggesting that any communication from HD or Highline contributed in any way to such a mistaken belief. Similarly, to the extent the Hamakers refused to believe HD's letters dated June 26, 2014 stating that Highline was withdrawing its liens based on their mistaken belief that Chapter 60.44 RCW required claimants to file lien releases with the county auditor, which it never did and does not now, they also failed to identify any evidence to support their false expectations.

At the summary judgment hearing before the trial court, Highline pointed out that the $1,110.72 paid to Highline by the Hamakers could not establish an injury under any theory of recovery because the Hamakers admitted that Highline provided medical services to them and had a right to payment of the undisputed amount of $1,666. RP 39-41. Highline also pointed out that the Hamakers' claim that it improperly bypassed their insurance was a red herring, given (1) Hamakers' voluntary choice to withhold their insurance information from Highline; (2) their acknowledgment that any insurance company that had actually paid for

medical services necessitated by a tortious act would have a subrogation interest in their settlement proceeds; and (3) the lack of any duty requiring Highline to further investigate the Hamakers' decision not to provide their insurance information. CP 456, 665, 710; RP 39, 86-87. The trial court granted summary judgment after a careful review of the evidence presented.

C. The Court of Appeals concluded that the Hamakers' payment of their valid debt was a cognizable injury, regardless of its cause.

The Court of Appeals reversed under the mistaken notions that (1) Highline had some role in charging or collecting $542 from each of the Hamakers for "physician fees," which the evidence established it did not; (2) Highline and HD never "asked the Hamakers" if they wanted to used their insurance, which the consent to treat form and HD's initial letter establish that they did; (3) Highline had some obligation to bill the Hamakers directly before filing a notice of claim to a lien, which no statute, contract, or rule requires; (4) Highline had some obligation to "file" or "record" a "release" to prove it would no longer assert a lien claim under the May 2014 notices, which RCW 60.44.060 never required; (5) Highline's "delay" in billing UMR until the Hamakers actually provided their insurance information and so requested somehow prevented UMR from paying the charges, when it was UMR's independent decision based on its interpretation of its own policy that actually prevented payment; and (6)

Highline and HD's aborted attempts to assert a lien claim somehow "forced" the Hamakers to pay their outstanding bill out of a settlement they voluntarily negotiated for that purpose, when there was never any enforcement action and the Hamakers were always free to enter negotiations with Highline at any time in order to reduce or resolve their admittedly valid debt. Because the decision of the Court of Appeals is contrary to the facts and in conflict with Washington law, this Court should grant review.

V. ARGUMENT WHY REVIEW SHOULD BE ACCEPTED

Highline seeks review under RAP 13.4(b)(1), (2), and (4).

A. The Court of Appeals ignored Washington law holding that voluntary payment of an admitted debt, without more, is not actionable.

In *Panag v. Farmers Ins. Co. of Wash.*, 166 Wn.2d 27, 204 P.3d, 885 (2008), this Court clarified that the five-part test for a CPA claim described in *Hangman Ridge Training Stables Inc. v. Safeco Title Ins. Co.*, 105 Wn.2d 778, 784, 719 P.2d 531 (1986), "incorporates the issue of standing, particularly the elements of public interest impact and injury." Although "a consumer or business relationship" between the plaintiff and defendant is not required, the "necessary" and "needed link between the plaintiff" and the defendant is that a "violation" of the CPA, that is, "wrongdoing" by a "wrongdoer," "***cause*** injury" to the plaintiff's business or property. *Panag*, 166 Wn.2d at 39-40. The five elements are "(1) an

unfair or deceptive act or practice, (2) occurring in trade or commerce, (3) affecting the public interest, (4) injury to a person's business or property, and (5) causation." *Id*. at 37. "Whether a particular act or practice is "unfair or deceptive" is a question of law." *Id*. at 47.

Panag involved communications from a collection agency to underinsured motorists in an effort to collect on an insurance company's subrogation claim. *Id*. at 34. The "wrongdoing" at issue was the collection agency's use of notices that "look[ed] like debt collection notices" and had to capacity to "induce people to remand payment in the mistaken belief they have the obligation to do so when in fact the notices represent[ed] nothing more than an unadjudicated claim for tort damages." *Id*. at 48. One plaintiff alleged sufficient injury by stating that he lost business profits when consulting with an attorney as a result of false statements in the notices about "collections." *Id*. at 57. Another plaintiff raised a question of fact for trial as to injury by identifying expenses incurred investigating the legal ramifications of the subrogation claim. *Id*. at 62, 65.

In *Panag*, this Court described with approval the opinion in *Flores v. Rawlings Co.*, 117 Haw. 153, 177 P.3d 341 (2008), holding that plaintiffs who paid less than they actually owed for medical expenses did not suffer a cognizable injury under the CPA because "the only deceptive practice at issue – engaging in unregistered collection activities – was not causally

related to the alleged injury." *Panag*, 166 Wn.2d at 61. Validity of a debt may be irrelevant only if expenses are incurred because of a "statutory violation and not because of a valid debt." *Id.* at 62. "The issue is whether the plaintiff was wrongfully induced to pay money on a debt not owed or to incur expenses" that would not have been incurred "but for the defendant's unfair or deceptive practice." *Id.* at 58-59, 62.

Here, it was undisputed that the Hamakers owed a valid debt of $1,666 to Highline Medical Center for medical services provided on May 30, 2012. Under *Panag*, evidence that the Hamakers paid less than that valid debt is not sufficient to raise a question for trial as to a CPA injury unless some unfair or deceptive practice by Highline induced them to incur expenses that would not otherwise have been incurred. There was no unfair or deceptive practice. No authority required Highline to identify a specific amount of the charges or bill the Hamakers before filing a notice of lien claim under Chapter 60.44 RCW; no authority has ever required a medical services lien claimant to "record" or "file" a "release" with the county auditor, *see* RCW 60.44.060(2) (current statute does not require "recording" or "filing" of release); former RCW 60.44.060 (Laws of 2012, Ch. 117, § 153) (statute in effect when relevant events occurred did not mention release). Highline never filed a lawsuit to enforce its lien claim. Highline did nothing to "force" the Hamakers to do anything. The Hamakers

voluntarily withheld their private insurance information from Highline and HD, voluntarily negotiated and accepted a settlement with American Commerce based, in part, on the amount of Highline's bills after HD accurately stated that Highline would not pursue its lien claim, and voluntarily sent a reduced payment to Highline several months later.

In sum, the Court of Appeal decision conflicts with this Court's decision in *Panag* because it holds that a plaintiff can present a prima facie case of a CPA violation by alleging payment of less than a valid debt without any evidence of injury causally related to any act that can be considered unfair or deceptive conduct as a matter of law.

The Court of Appeals also concluded that the Hamakers identified an injury sufficient to support a claim for unjust enrichment because "they paid Highline $1,110.72." *Slip. Op.* at 2, 10 n.8, 11. But, the undisputed evidence presented to the trial court established that the Hamakers acknowledged, and voluntarily paid and a valid debt of $1,666 to Highline for medical services. CP 456, 468. In *Lynch v. Deaconess Med. Ctr.*, 113 Wn.2d 162, 166, 776 P.3d 681 (1989), this Court stated that "[i]t is well established that unjust enrichment and liability only occur where money or property had been placed in a party's possession such that in equity and good conscience, the party should not retain it." Because the hospital defendant in *Lynch* did not receive more than it was owed for the medical

services it provided, it was "clear that it would not be unjust" for the hospital to retain it. *Id.* Despite citing *Lynch* for that proposition, the Court of Appeals reached the opposite conclusion here without analysis or explanation. *Slip Op.* at 10 n.8, 11. Moreover, contrary to the characterization of the Court of Appeals, the Hamakers were not "forced" to pay Highline in April 2015; no court order or judgment compelled them and nothing in HD's June 2014 letters communicating withdrawal of the lien claims or Highline's last relevant act of following the Hamaker's September 2014 request to bill UMR suggested that the Hamakers were under some threat of enforcement. Just as their decisions to withhold their insurance information, negotiate their personal injury settlement, and seek later payment from UMR, the Hamakers' decision to direct their attorney to pay Highline out of their settlement was *voluntary*. "It is a universally recognized rule that money voluntarily paid under a claim of right to the payment, and with knowledge by the payor of the facts on which the claim is based, cannot be recovered" by an unjust enrichment claim. *Hawkinson v. Conniff*, 53 Wn.2d 454, 458, 334 P.3d 540 (1959).

Given the lack of any evidence of injury resulting from any knowing and materially false statements by Highline regarding its charges for medical services rendered, or from any violation of any duty, Highline was also entitled to summary judgment dismissal of the Hamakers' claims for

fraud and negligence and the Court of Appeals' conclusion to the contrary is in conflict with well-settled law. *See, e.g., Alhadeff v. Meridian Bainbridge Island, LLC,* 167 Wn.2d 601, 618, 220 P.3d 1214 (2009); *Adams v. King County*, 164 Wn.2d 640, 662, 192 P.3d 892 (2008).

B. The Court of Appeals ignored well-settled Washington law applicable to the debtor-creditor relationship between the Hamakers and Highline Medical Center.

In the context of debtor-creditor relationship between the Hamakers and Highline, *see, e.g., Lynch*, 113 Wn.2d at 167, Washington law provides options to a creditor hospital. First, obviously, Highline could have opted not to attempt collection of any payment whatsoever, particularly in light of statutory requirements for provision of charity care. *See, e.g.,* RCW 70.170.060; *Audit & Adjustment Co. v. Earl*, 165 Wn. App. 497, 499, 505, 267 P.3d 441 (2011) (qualifications for charity care as an affirmative defense to debt collection action for unpaid hospital bills). Not only did Highline advise the Hamakers of the existence of its charity care program, CP 456, nothing in the record suggests that Highline would be legally prevented from applying such a program to the charges incurred here.

Second, to the extent it sought payment directly from the Hamakers or their insurer, Highline would obviously be required to comply with applicable regulations as well as the CPA, avoiding any unfair or deceptive debt collection practices. *See, e.g., Panag*, 166 Wn.2d at 40-44 (CPA

provides protection to the public for collection practices not already subject to regulation of insurance and debt collection industries). And, to the extent Highline had departed from the financial arrangements to which the Hamakers had agreed in their consent to treat form, questions as to the enforceability of that agreement could conceivably be presented in a lawsuit. *See, e.g., Pitell v. King County Pub. Hosp. Dist. No.2,* 4 Wn. App. 2d 764, 423 P.3d 900 (2018) (considering patient's challenge to enforceability of consent to care form based on lack of definite price term).

But, the Hamakers never claimed that any communication by Highline about billing was unfair or deceitful, never disputed the amount charged by Highline, and never questioned the enforceability of any financial agreement with Highline – they only alleged technical deficiencies in notices of claim that were never the subject of any enforcement action and expired by the terms of the statute before Highline received any payment. Highline did not violate the CPA or any other statute, regulation, contract, or common law rule in its communications with the Hamakers on May 30, 2012, when they received, but did not pay for hospital services, in January 2013, when Mr. Hamaker contacted Highline and was directed to HD, in July 2014, when Highline issued bills directly to the Hamakers, or in September 2014, when Highline followed their request to bill UMR.

Third, Highline had the option to pursue "an additional remedy for

the collection of" the debt under Chapter 60.44 RCW. *See Layton v. Home Indem. Co.*, 9 Wn.2d 25, 35, 113 P.2d 538 (1943). That statute does not suggest that a medical provider with a right to claim a lien has any duty to seek payment directly from the patient before or after asserting a lien claim or filing a suit to enforce a lien; even the current version of the statute does not suggest an obligation to inform or bill a patient's insurer. *See generally* Chapter 60.44 RCW. Nothing in the statute suggests that a medical provider can be liable for a CPA violation or any other "wrongdoing" by simply filing a notice of claim that facially complies with the requirements of former RCW 60.44.020.

Finally, if UMR had paid Highline's bills as the Hamakers requested, UMR would have had subrogation rights against any settlement the Hamakers obtained from American Commerce. *See*, *e.g.*, *Mut. Of Enumclaw Ins. Co. v. USF Ins. Co.*, 164 Wn.2d 411, 423-24, 191 P.3d 866 (2008). The Hamakers even acknowledged that their settlement proceeds were subject to the subrogation rights of the insurers who had paid other charges incurred as a result of the same accident. CP 468. In light of this well-settled law, the injury embraced by the Court of Appeals is illusory.

C. The Court of Appeals' erroneous view of the language and operation of Chapter 60.44 RCW involves an issue of substantial public interest that should be determined by this Court.

Although Washington has had a medical services lien statute,

chapter 60.44 RCW, for over 80 years, Washington courts have rarely interpreted it. *See, e.g.*, *Layton*, 9 Wn.2d at 35. By its plain language, however, the statute clearly provides that the filing of a notice of claim *merely entitles a claimant to seek enforcement of a lien by filing a lawsuit within one year*; nothing in the statute suggests that a claimant who files a notice must necessarily seek enforcement and it is not self-executing. Former RCW 60.44.020 (Laws of 1975, 1st Ex. S., Ch. 250, § 2); Chapter 60.44 RCW. Similarly, nothing in the statute requires a lien claimant to file or record any *release* of a notice of claim with the county auditor under any circumstances. *See* former RCW 60.44.060 (2012); RCW 60.44.060(2). The Legislature clearly considered the one-year time limit for filing a lawsuit based on a recorded notice of claim was sufficient. *Id.*

Despite the lack of case law suggesting that a hospital risks violating the CPA and incurring civil liability by attempting to preserve a claim to a lien under Chapter 60.44 RCW, the Court of Appeals concluded in this case that Highline's mere filing of notices of claim could expose Highline to cognizable claims of violation of the CPA, negligence, fraud, and unjust enrichment. In contrast, the United States Court of Appeals for the Ninth Circuit recently affirmed the summary judgment dismissal of CPA and negligence claims based on a hospital's use of medical liens for a failure to identify evidence of injury *causally connected* to any unfair or deceptive

act. *Grego v. Kadlec Regional Medical Center*, No. 18-35064 (March 18, 2019) (copy of Memorandum opinion attached). In *Grego*, the plaintiffs alleged that the hospital violated the CPA by choosing to file lien claims rather than bill the patients' insurer, specifically Medicare or Medicaid. *Memo*. at 3. But, the Ninth Circuit held that the hospital "was acting in a way permitted by Washington's medical lien statute and in accordance with federal Medicare and Medicaid laws." *Id*. Although one plaintiff identified a potential CPA claim based on evidence that a defendant knowingly pursued full payment of an amount greater than the statutory limit, there was no evidence to support the causation element because her attorney's voluntary act was the source of her injury. *Id*. at 4-5. In a footnote, the Court rejected the plaintiffs claim that the "existence of recorded—but expired—liens is an injury" because it was not based on evidence in the record and because such an injury "could not be the result of a deceptive or unfair act because the liens were valid" based on notices filed pursuant to RCW 60.44.020. *Id*. at 5-6 n.1. This Court should speak on these issues.

VI. CONCLUSION

The decision of the Court of Appeals is contrary to well-settled law and will invite additional litigation against medical professionals who act in a way explicitly permitted by Washington's medical lien statute. For all these reasons, the Petition for Review should be accepted.

RESPECTFULLY SUBMITTED this 20th day of May, 2019.

s/Jennifer D. Koh
Jennifer D. Koh, WSBA #25464
Caitlyn Y. Portz, WSBA #51437
Attorneys for Respondent Highline Medical Center
FAIN ANDERSON VANDERHOEF ROSENDAHL O'HALLORAN SPILLANE, PLLC
701 Fifth Avenue, Suite 4750
Seattle, WA 98104
Ph: 206.749.0094
Fx: 206.749.0194
Email: jennifer@favros.com
caitlyn@favros.com

NOT FOR PUBLICATION

FILED

MAR 18 2019

MOLLY C. DWYER, CLERK
U.S. COURT OF APPEALS

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

ANDREW GREGO and MARIA DOROSHCHUK, individually and on behalf of all others similarly situated, Plaintiffs-Appellants, v. KADLEC REGIONAL MEDICAL CENTER, a Washington non-profit corporation; et al., Defendants-Appellees.	No. 18-35064 D.C. No. 4:16-cv-05150-RMP MEMORANDUM*

Appeal from the United States District Court
for the Eastern District of Washington
Rosanna Malouf Peterson, District Judge, Presiding

Argued and Submitted March 4, 2019
Seattle, Washington

Before: GOULD and PAEZ, Circuit Judges, and BASHANT,** District Judge.

Andrew Grego ("Grego") and Maria Doroshchuk ("Doroshchuk")

(collectively, the "Plaintiffs") appeal the district court's order granting summary

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* This disposition is not appropriate for publication and is not precedent except as provided by Ninth Circuit Rule 36-3.

** The Honorable Cynthia A. Bashant, United States District Judge for the Southern District of California, sitting by designation.

judgment for Kadlec Regional Medical Center ("Kadlec") and Cardon Healthcare Network, LLC and Cardon Healthcare Holdings ("Cardon"). We review de novo a district court's grant of summary judgment. *James River Ins. Co. v. Hebert Schenk, P.C.*, 523 F.3d 915, 920 (9th Cir. 2008). We affirm.

I.

Where a medical provider treats a patient for traumatic injuries caused by a tortfeasor, Washington law authorizes the medical provider to place a lien on the patient's recovery from the tortfeasor or her insurer. Wash. Rev. Code § 60.44.010. The medical lien law limits the lien amount to 25 percent of the settlement. *Id*. A notice of the lien signed by the claimant must be filed with the auditor of the county where medical services were provided. *Id*. § 60.44.020. The liens expire one year after filing. *Id*. § 60.44.060.

Kadlec is a not-for-profit private corporation that operates a hospital. The Plaintiffs were treated for traumatic injuries at Kadlec's hospital. The bill for Doroshchuk's treatment was $8,555. The bill for Grego's treatment was $79,748.09.

Kadlec contracted with Cardon for certain billing services, including filing medical liens. On Kadlec's behalf, Cardon filed liens on the Plaintiffs' recovery from the tortfeasors. The values recorded and demanded with the lien were for the total cost of medical services rendered.

The Plaintiffs retained a personal injury attorney ("PI Attorney") to recover money from the tortfeasors. Doroshchuk's claim settled for $25,000, and therefore the total cost of medical services rendered exceeded the 25 percent statutory limit. After learning of the settlement amount, Cardon continued to pursue the full cost of Doroshchuk's medical services. The PI Attorney appears to have placed that amount in trust.

Grego recovered $250,000 from the tortfeasor, and therefore the total cost of medical services rendered exceeded the 25 percent statutory limit. The record does not reflect that Cardon or Kadlec ever learned of Grego's settlement amount. The PI Attorney initially retained in trust a portion of the settlement in excess of the 25 percent limit, but less than the full amount of Grego's medical bills. At Grego's request, the PI Attorney released the full amount to Grego.

The Plaintiffs have not paid for their medical services, and Kadlec has not received any payment for the Plaintiffs' treatment. The liens have expired. *See* Wash. Rev. Code § 60.44.060.

II.

The Plaintiffs contest Kadlec's "election" to pursue payment via lien rather than from Medicare or Medicaid. By seeking payment from a liable tortfeasor, however, Kadlec was acting in a way permitted by Washington's medical lien statute and in accordance with federal Medicare and Medicaid laws. 42 U.S.C.

§§ 1395y(b)(2)(A), 1396a(25)(A)-(B); Wash. Rev. Code § 60.44.010 .

III.

The Plaintiffs argue that the liens were invalid because they were signed by Cardon rather than the "claimant." Wash. Rev. Code § 60.44.020.

As the "operator . . . of a hospital" that treated the Plaintiffs for traumatic injuries, Kadlec is the claimant. Wash. Rev. Code § 60.44.010. Kadlec is a not-for-profit corporation, and "like any corporation, can act only through its agents." *Houser v. Redmond*, 586 P.2d 482, 485 (Wash. 1978). Cardon was Kadlec's agent for purposes of pursuing third-party liability services, and on each notice the Cardon signor identified himself or herself as an "Agent for KADLEC." The liens were claimed by Kadlec and properly signed by its agent, therefore the liens themselves were valid.

IV.

The Plaintiffs also argue that Kadlec and Cardon's practice of pursuing more than the statutory cap on lien collections is a deceptive practice under Washington's Consumer Protection Act ("CPA"). Wash. Rev. Code § 19.86.020.

"To prevail in a private CPA claim, the plaintiff must prove (1) an unfair or deceptive act or practice, (2) occurring in trade or commerce, (3) affecting the public interest, (4) injury to a person's business or property, and (5) causation." *Panag v. Farmers Ins. Co. of Wash.*, 204 P.3d 885, 889 (Wash. 2009). "Whether

a particular act or practice is 'unfair or deceptive' is a question of law." *Id*. at 894 (citation omitted). "[T]here must be some demonstration of a causal link" between the deceptive act and the injury. *Indoor Billboard v. Integra Telecom of Wash., Inc.*, 170 P.3d 10, 22 (Wash. 2007).

It was not deceptive for Cardon and Kadlec to seek full payment from both Plaintiffs before the Plaintiffs settled with the tortfeasors because none of the parties knew whether the bill exceeded the statutory limit. Similarly, before Cardon and Kadlec learned of a settlement amount, it was not deceptive to seek full payment. Because Cardon and Kadlec did not learn the amount of Grego's settlement while seeking payment, there was no deceptive act with respect to Grego. After knowledge of Doroshchuk's settlement amount, however, Cardon and Kadlec's pursuit of full payment is analogous to "debt collection practices . . . where there is no dispute as to the validity of the underlying debt," which can be the basis of a CPA claim. *Frias v. Asset Foreclosure Servs., Inc.*, 334 P.3d 529, 538 (Wash. 2014).

Doroshchuk's loss of use of her settlement funds in excess of the 25 percent subject to medical services liens that the PI Attorney placed in trust was an injury under the CPA.[1] *See Sorrel v. Eagle Healthcare, Inc.*, 38 P.3d 1024, 1029 (Wash.

[1] Additionally, the Plaintiffs argue the existence of recorded—but expired—liens is an injury. Any such injury is not based on evidence in the record. Moreover, this

Ct. App. 2002). But the causal link between her injury and the deceptive act is missing. The PI Attorney could have retained in trust only the amount recoverable under the medical lien statute, or he could have released the funds to Doroshchuk as he did for Grego. The district court correctly held that the necessary causation element was missing for Doroshchuk's CPA claim. Because Grego failed to establish a deceptive practice and Doroshchuk failed to establish causation, the district court did not err in granting summary judgment to Cardon and Kadlec.[2]

AFFIRMED.

injury could not be the result of a deceptive or unfair act or practice because the liens were valid.

[2] The Plaintiffs also alleged a negligence claim, and the district court concluded causation was missing for that claim as well. The Plaintiffs' appellate briefing focused on the CPA, but to the extent they still claim negligence, we agree with the district court.

United States Court of Appeals for the Ninth Circuit

Office of the Clerk
95 Seventh Street
San Francisco, CA 94103

Information Regarding Judgment and Post-Judgment Proceedings

Judgment

- This Court has filed and entered the attached judgment in your case. Fed. R. App. P. 36. Please note the filed date on the attached decision because all of the dates described below run from that date, not from the date you receive this notice.

Mandate (Fed. R. App. P. 41; 9th Cir. R. 41-1 & -2)

- The mandate will issue 7 days after the expiration of the time for filing a petition for rehearing or 7 days from the denial of a petition for rehearing, unless the Court directs otherwise. To file a motion to stay the mandate, file it electronically via the appellate ECF system or, if you are a pro se litigant or an attorney with an exemption from using appellate ECF, file one original motion on paper.

Petition for Panel Rehearing (Fed. R. App. P. 40; 9th Cir. R. 40-1)
Petition for Rehearing En Banc (Fed. R. App. P. 35; 9th Cir. R. 35-1 to -3)

(1) A. Purpose (Panel Rehearing):

- A party should seek panel rehearing only if one or more of the following grounds exist:
  - A material point of fact or law was overlooked in the decision;
  - A change in the law occurred after the case was submitted which appears to have been overlooked by the panel; or
  - An apparent conflict with another decision of the Court was not addressed in the opinion.
- Do not file a petition for panel rehearing merely to reargue the case.

B. Purpose (Rehearing En Banc)

- A party should seek en banc rehearing only if one or more of the following grounds exist:

- ► Consideration by the full Court is necessary to secure or maintain uniformity of the Court's decisions; or
- ► The proceeding involves a question of exceptional importance; or
- ► The opinion directly conflicts with an existing opinion by another court of appeals or the Supreme Court and substantially affects a rule of national application in which there is an overriding need for national uniformity.

(2) Deadlines for Filing:

- A petition for rehearing may be filed within 14 days after entry of judgment. Fed. R. App. P. 40(a)(1).
- If the United States or an agency or officer thereof is a party in a civil case, the time for filing a petition for rehearing is 45 days after entry of judgment. Fed. R. App. P. 40(a)(1).
- If the mandate has issued, the petition for rehearing should be accompanied by a motion to recall the mandate.
- *See* Advisory Note to 9th Cir. R. 40-1 (petitions must be received on the due date).
- An order to publish a previously unpublished memorandum disposition extends the time to file a petition for rehearing to 14 days after the date of the order of publication or, in all civil cases in which the United States or an agency or officer thereof is a party, 45 days after the date of the order of publication. 9th Cir. R. 40-2.

(3) Statement of Counsel

- A petition should contain an introduction stating that, in counsel's judgment, one or more of the situations described in the "purpose" section above exist. The points to be raised must be stated clearly.

(4) Form & Number of Copies (9th Cir. R. 40-1; Fed. R. App. P. 32(c)(2))

- The petition shall not exceed 15 pages unless it complies with the alternative length limitations of 4,200 words or 390 lines of text.
- The petition must be accompanied by a copy of the panel's decision being challenged.
- An answer, when ordered by the Court, shall comply with the same length limitations as the petition.
- If a pro se litigant elects to file a form brief pursuant to Circuit Rule 28-1, a petition for panel rehearing or for rehearing en banc need not comply with Fed. R. App. P. 32.

- The petition or answer must be accompanied by a Certificate of Compliance found at Form 11, available on our website at www.ca9.uscourts.gov under *Forms.*
- You may file a petition electronically via the appellate ECF system. No paper copies are required unless the Court orders otherwise. If you are a pro se litigant or an attorney exempted from using the appellate ECF system, file one original petition on paper. No additional paper copies are required unless the Court orders otherwise.

Bill of Costs (Fed. R. App. P. 39, 9th Cir. R. 39-1)

- The Bill of Costs must be filed within 14 days after entry of judgment.
- See Form 10 for additional information, available on our website at www.ca9.uscourts.gov under *Forms.*

Attorneys Fees

- Ninth Circuit Rule 39-1 describes the content and due dates for attorneys fees applications.
- All relevant forms are available on our website at www.ca9.uscourts.gov under *Forms* or by telephoning (415) 355-7806.

Petition for a Writ of Certiorari

- Please refer to the Rules of the United States Supreme Court at www.supremecourt.gov

Counsel Listing in Published Opinions

- Please check counsel listing on the attached decision.
- If there are any errors in a published opinion, please send a letter **in writing within 10 days** to:
  - ► Thomson Reuters; 610 Opperman Drive; PO Box 64526; Eagan, MN 55123 (Attn: Jean Green, Senior Publications Coordinator);
  - ► and electronically file a copy of the letter via the appellate ECF system by using "File Correspondence to Court," or if you are an attorney exempted from using the appellate ECF system, mail the Court one copy of the letter.

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Form 10. Bill of Costs

Instructions for this form: http://www.ca9.uscourts.gov/forms/form10instructions.pdf

9th Cir. Case Number(s)

Case Name

The Clerk is requested to award costs to (*party name(s)*):

I swear under penalty of perjury that the copies for which costs are requested were actually and necessarily produced, and that the requested costs were actually expended.

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CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury that under the laws of the State of Washington that on the 20th day of May, 2019, I caused a true and correct copy of the foregoing document, "Petition for Review," to be delivered in the manner indicated below to the following counsel of record:

Counsel for Respondents:
Darrell L. Cochran, WSBA #22851
Loren A. Cochran, WSBA #32773
Christopher E. Love, WSBA #42832
PFAU COCHRAN VERTETIS AMALA, PLLC
911 Pacific Avenue, Suite 200
Tacoma, WA 98402
Ph: 253.777.0799
Email: darrell@pcvalaw.com
loren@pcvalaw.com
chris@pcvalaw.com

SENT VIA:
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☑ E-file / E-mail

DATED this 20th day of May, 2019, at Seattle, Washington.

s/Carrie A. Custer
Carrie A. Custer, Legal Assistant

FILED
3/25/2019
Court of Appeals
Division I
State of Washington

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

PAUL HAMAKER, individually and as a putative class representative, and JOSEPHINE HAMAKER, individually and as a putative class representative,

Appellant,

v.

HIGHLINE MEDICAL CENTER, a Washington non-profit corporation,

Respondent,

REBECCA A. ROHLKE, individually, on behalf of the marital community and as agent of non-party Hunter Donaldson; JOHN DOE ROHLKE, on behalf of the marital community; RALPH WADSWORTH, individually, on behalf of the marital community, and as agent of nonparty Hunter Donaldson, JANE DOE WADSWORTH, on behalf of the marital community; TIM CARDA, individually, on behalf of the marital community, and as agent of non-party Hunter Donaldson, JANE DOE CARDA, on behalf of the marital community; GRACIELA PULIDO, individually, on behalf of the marital community and as agent of non-party Hunter Donaldson, JOHN DOE PULIDO, on behalf of the marital community, KIMBERLY WADSWORTH, individually, on behalf of the marital community and as agent of nonparty Hunter Donaldson, and JOHN DOE WADSWORTH, on behalf of the marital community,

Defendants.

No. 77578-2-I

DIVISION ONE

UNPUBLISHED OPINION

FILED: March 25, 2019

CHUN, J. — After Paul and Josephine Hamaker (the Hamakers) suffered injuries in a car accident for which they were not at fault, they received medical treatment at Highline Medical Center (Highline). Under an agreement with Highline, Hunter Donaldson, LLC (HD) recorded medical liens on Highline's behalf against the tortfeasor's insurer. After Highline discovered HD had filed improperly notarized liens, it instructed HD to withdraw medical liens previously recorded. HD, however, did not record corresponding lien releases for several years. Prior to the recording of lien releases as to their obligations, the Hamakers settled their personal injury case and paid Highline for their medical bills out of their recovery.

The Hamakers then filed a putative class action complaint against Highline for declaratory and injunctive relief, alleging negligence, fraud, unjust enrichment, and violations of the Consumer Protection Act (CPA).[1] The parties filed cross-motions for summary judgment and the Hamakers additionally filed a motion for class certification. The court granted summary judgment for Highline and dismissed all of the Hamakers' claims for lack of standing. Because the Hamakers raised a genuine issue as to whether they suffered an injury such that they may bring their claims, we reverse.

I.
BACKGROUND

On March 1, 2011, Highline entered a First and Third Party Liability Recovery Service Agreement (the Agreement) with HD. The Agreement allowed

[1] The additional defendants (employees of HD) were not involved in the summary judgment dismissal and are not involved in this appeal.

HD, on Highline's behalf, to record and collect on medical services liens against third-party tortfeasors responsible for a patient's injuries.

The Hamakers suffered a rear-end vehicular collision on May 30, 2012. Highline treated the Hamakers for injuries sustained in the accident and coded their medical accounts as "01" to indicate they had sought care due to injuries sustained in a motor vehicle accident. Highline charged $542.85 to each of the Hamakers for physician services. The Hamakers paid the charges with their credit card. Although the Hamakers had commercial health insurance with United Healthcare/UMR (UMR), they chose not to give Highline their health insurance information. The Hamakers preferred to pay out of pocket and then seek reimbursement because the accident was another's fault.

Because of the "01" code on the Hamakers' accounts, Highline automatically transferred the accounts to HD for processing and management. On June 27, 2012, HD recorded notices of a claim to a medical services lien. The notices identified the Hamakers as patients and American Commerce Insured (the tortfeasor's insurer) as the tortfeasor. Rebecca Rohlke served as the notary. The Hamakers learned of these notices on June 29, 2012.

Paul[2] called Highline to inquire about the medical services lien on January 15, 2013. Highline directed him to HD. HD told him there was an outstanding bill "for the facility" separate from the previously satisfied bill for

[2] For clarity, we refer to Paul and Josephine Hamaker by their first names when individually referenced. We intend no disrespect.

physician services. HD also informed Paul it had filed the lien against the tortfeasor's insurer because it was responsible for his bills.

Throughout 2013, the Hamakers incurred additional accident-related medical expenses from other healthcare providers. These providers submitted the medical bills to UMR, and UMR paid them.

On May 1, 2013, the Notary Public Program of the Washington State Department of Licensing received a complaint that Rohlke had falsely notarized medical liens. Rohlke voluntarily resigned her notary appointment on May 31, 2013.

HD sent two notices of recorded lien claim (one for each of the Hamakers) to the Hamakers' personal injury attorney[3] on April 29, 2014. The notices provided as follows:

> Hunter Donaldson, LLC is the authorized agent of **Highline Medical Center.** NOTICE IS HEREBY GIVEN THAT **Highline Medical Center** claims a lien on any damages that the patient named above may recover. Our Lien was duly executed and recorded. It is your legal obligation to make sure that this lien is paid, if payment is received from any settlement, recovery, and or judgment, pursuant to RCW 60.44.010.

On June 20, 2014, after learning of litigation surrounding Rohlke's false notarizations, Highline directed HD to withdraw all lien claims and to stop executing further claims.

The Hamakers' attorney received two additional letters from HD (again one for each of the Hamakers) on June 26, 2014. The letters stated, "As the duly

[3] The Hamakers hired Christopher Williams to represent them in their personal injury claims related to the automobile accident.

authorized recovery agent for **Highline Medical Center**, please be advised that our office is withdrawing our lien for medical services rendered to the above-referenced plaintiff." However, HD did not record lien releases at that time.

The facility charges remained on the Hamakers' accounts. The Hamakers received two statements dated July 20, 2014 indicating that they each owed $833 to Highline.

In September 2014, the Hamakers provided proof of UMR as their primary insurer. Highline then billed UMR $833 for each Hamaker. On October 23, 2014, UMR denied both claims as untimely. Highline then wrote off the $833 balance on each account on November 7, 2014.

The Hamakers settled their personal injury case for $16,343.43,[4] and signed releases on March 27, 2015.

On April 20, 2015, the Hamakers directed their attorney to "pay to Highline medical center $1110.72 for our medical bill. I recognize the medical bill is $1660 but [our personal injury attorney] is reducing their fees pursuant to Mahler."[5] Highline received the payment on May 27, 2015 and applied it equally to Paul and Josephine's accounts ($555.36 to each account). Highline wrote off each account's remaining balance.

The Hamakers filed their putative class action complaint on February 4, 2016. The complaint asserted claims against Highline for declaratory and

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[4] $8,343.43 and $8,000 to Paul and Josephine respectively.

[5] The Hamakers appear to have been referring to Mahler v. Szucs, 135 Wn.2d 398, 957 P.2d 632 (1998), which supports reducing an insurance company's recovery from an insured's settlement for subrogation payments by a pro rata share of an insured's legal costs in obtaining the settlement.

injunctive relief, violations of the Consumer Protection Act (CPA), negligence, fraud, and unjust enrichment against Highline.[6] Each claim arose from HD's lien practices and the false notarization of the liens.

On July 12, 2017, Highline recorded releases for the liens against the Hamakers' recovery.

On August 4, 2017, Highline moved for summary judgment. Highline asserted (1) the Hamakers "lack[ed] standing to challenge the validity of the notices of claim"; (2) the Hamakers could not "present a genuine issue of material fact on the essential element of damages"; and (3) it "is not liable for acts of independent contractor, [HD]."

Also on August 4, 2017, the Hamakers filed two cross-motions for partial summary judgment and a motion for class certification. The first partial summary judgment motion requested the trial court rule that all of the falsely notarized medical services liens filed by HD were invalid as a matter of law. The second sought declaratory relief that the medical services liens were unenforceable due to passage of time. The motion further asked the court to require Highline to "create" releases for the unenforceable liens and pay the fees to file them.

The trial court granted summary judgment in favor of Highline "for lack of standing" on October 27, 2017. That same day, the trial court denied both of the Hamakers' cross-motions for partial summary judgment and their motion for class certification, also for lack of standing. In early 2018, the trial court entered an order granting the Hamakers' motion for CR 54(b) certification and stay of

[6] The complaint included additional claims against other defendants.

proceedings regarding its claims against the non-Highline defendants pending appeal.

II.
ANALYSIS

A. Non-CPA Claims

Highline argues the Hamakers lack standing to bring their claims for declaratory and injunctive relief, negligence, fraud, and unjust enrichment. First, with respect to the claim for declaratory relief, Highline contends the Hamakers fall outside the zone of interests of RCW 60.44. Additionally, Highline asserts the Hamakers do not have standing to bring any of their non-CPA claims because they have not demonstrated a cognizable injury. The Hamakers assert they fall within the statute's zone of interests, and were injured by their $1,110.72 payment to Highline from their settlement. We determine the Hamakers have standing to bring their non-CPA claims because they (1) fall within the statute's zone of interests; and (2) have raised a genuine issue of fact as to whether they suffered an injury.

Appellate courts review de novo a grant of summary judgment. Fed. Way Sch. Dist. No. 210 v. State, 167 Wn.2d 514, 523, 219 P.3d 941 (2009). Courts view all reasonable inferences in the light most favorable to the nonmoving party and will grant summary judgment only where there are no genuine issues of material fact such that the nonmoving party is entitled to judgment as a matter of law. Fed. Way Sch. Dist. No. 210, 167 Wn.2d at 523.

The question of standing constitutes a threshold issue that courts review de novo. In re Estate of Becker, 177 Wn.2d 242, 246, 298 P.3d 720 (2013).

The standing doctrine requires a plaintiff to have a personal stake in the outcome of the case to bring a suit. Germeau v. Mason County, 166 Wn. App. 789, 803, 271 P.3d 932 (2012).

1. Declaratory Relief – Zone of Interests

As to the Hamakers' claim for declaratory relief, the Uniform Declaratory Judgment Act (UDJA) requires the plaintiffs to show their "rights, status, or other legal relations are affected by a statute" to have standing. Five Corners Family Farmers v. State, 173 Wn.2d 296, 302, 268 P.3d 892 (2011). The Washington Supreme Court created a two-part test to determine whether a party has standing under the UDJA. Five Corners Family Farmers, 173 Wn.2d at 302. Under this test, the asserted interest must arguably fall within the zone of interests protected or regulated by the statute and the challenged action must have resulted in an injury-in-fact. Five Corners Family Farmers, 173 Wn.2d at 302-03. The party seeking standing bears the burden of proving it has met both elements. Branson v. Port of Seattle, 152 Wn.2d 862, 876, 101 P.3d 67 (2004).

The Hamakers' first claim requests a judicial declaration that HD's lien enforcement practices violated RCW 60.44. They argue their claim falls within the zone of interests protected by RCW 60.44 because it concerns if and how a lien may be secured on their property. Highline asserts the Hamakers' claim falls outside the zone because the statute seeks to regulate tortfeasors and claimants rather than patients.

When determining whether a claim falls within a statute's zone of interests, courts begin by looking at both the operation of the statute and its general purpose. Five Corners Family Farmers, 173 Wn.2d at 304-05. RCW 60.44.010 provides:

> Every operator, whether private or public, of an ambulance service or of a hospital, and every duly licensed nurse, practitioner, physician, and surgeon rendering service, or transportation and care, for any person who has received a traumatic injury and which is rendered by reason thereof shall have a lien upon any claim, right of action, and/or money to which such person is entitled against any tort-feasor and/or insurer of such tort-feasor for the value of such service, together with costs and such reasonable attorney's fees as the court may allow, incurred in enforcing such lien . . . PROVIDED, FURTHER, That all the said liens for service rendered to any one person as a result of any one accident or event shall not exceed twenty-five percent of the amount of an award, verdict, report, decision, decree, judgment, or settlement.

RCW 66.44.020 requires the notice of the lien to include "the name and address of the patient and place of domicile or residence."

Although the medical provider enforces the medical lien against the tortfeasor and their insurer, the payment to the medical provider comes from the funds recovered by the patient. When filing a notice of a medical lien, the medical provider must include the patient's information. Furthermore, the statute protects patients' interest in their claims by limiting the amount recoverable by a lien to 25 percent of the total received by the patient. To be sure, RCW 60.44 both protects and regulates the patient's interest in the funds he or she recovers.

As such, we conclude the Hamakers' claim falls within the zone of interests of RCW 60.44.[7]

2. Injury (as to all non-CPA claims)

As to all of the non-CPA claims, the Hamakers are required to prove an injury as either part of the test for standing under the UDJA or as an element for their cause of action.[8] The Hamakers contend they suffered an injury because they paid Highline $1,110.72 due to HD's lien practice and the false notarization. Highline argues the Hamakers paid the money because they chose not to provide Highline with their health insurance information. We determine the Hamakers raise a genuine issue of fact as to whether they suffered an injury.

Viewing the facts in the light most favorable to the Hamakers:

Highline maintained a practice of billing a patient's carrier when the patient had private health insurance. In the absence of a patient's health insurance information, Highline would mark the account as a "self-pay" account and send the patient a letter requesting insurance information.

Here, the Hamakers' account was marked as "self-pay" after they did not provide their health insurance information to Highline. The account was then

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[7] Highline additionally argues RCW 60.44 does not create a private right of action for a patient to seek redress where a lien holder has not sought to enforce the lien. But the Hamakers do not assert a private right of action under the statute. Rather, their claims derive from the UDJA, CPA, and common law. Accordingly, the absence of a private right of action under RCW 60.44 does not impede their claims. See Nelson v. Appleway Chevrolet, Inc., 160 Wn.2d 173, 187, 157 P.3d 847 (2007) ("no additional private right of action is necessary for parties to seek a declaratory judgment whenever their rights are affected by a statute").

[8] Five Corners Family Farmers, 173 Wn.2d at 302 (injury-in-fact required for declaratory relief); Alhadeff v. Meridian on Bainbridge Island, LLC, 167 Wn.2d 601, 618, 220 P.3d 1214 (2009) (injury required for negligence claim); Adams v. King County, 164 Wn.2d 640, 662, 192 P.3d 892 (2008) (injury required for fraud claim); Lynch v. Deaconess Med. Ctr., 113 Wn.2d 162, 165-66, 776 P.2d 681 (1989) (unjust enrichment claim requires plaintiff to prove a party recovered more than it was owed).

transferred to HD because Highline's code indicated the injuries arose from a motor vehicle accident. Instead of requesting health insurance information from the Hamakers when the bill for the facility fees arose, Highline immediately recorded medical liens. The Hamakers did not know they owed facility fees until they received the notice of the liens.

Neither Highline nor HD ever asked the Hamakers if they wanted the facility fees to be paid by their health insurer. Although the Hamakers used their credit card to pay the physician fees, they did not know of the facility fee at that time. Moreover, while the Hamakers originally chose to pay the physician fees out of pocket, they sent several other medical bills stemming from the accident to their insurer. Accordingly, filing the lien without first notifying the Hamakers that they owed money forced them to pay Highline out of their settlement. Thus, HD's decision to file a medical lien before informing the Hamakers of the facility fees deprived them of the choice to have their health insurer pay for the fees.

The foregoing raises a genuine issue of fact as to whether the Hamakers suffered an injury as a result of the alleged wrongful conduct. Accordingly, the trial court erred by dismissing the Hamakers' non-CPA claims on the ground that they lacked standing.

B. CPA Claims

The Hamakers assert they suffered multiple CPA injuries. Specifically, they point to (1) the $1,110.72 paid to Highline; (2) a decision to not refinance their home; and (3) the failure to record lien releases. Highline again claims the Hamakers did not suffer any injury caused by the liens. We agree with the

Hamakers and conclude they raise a genuine issue of material fact as to the injury element of their CPA claim.[9]

The CPA provides, "Unfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce are hereby declared unlawful." RCW 19.86.020. For a plaintiff to bring a claim under the CPA, he or she "must prove (1) an unfair or deceptive act or practice, (2) occurring in trade or commerce, (3) affecting the public interest, (4) injury to a person's business or property, and (5) causation." Panag v. Farmers Ins. Co. of Washington, 166 Wn.2d 27, 37, 204 P.3d 885 (2009), (citing Hangman Ridge Training Stables, Inc. v. Safeco Title Ins. Co., 105 Wn.2d 778, 784, 719 P.2d 531 (1986)).

A plaintiff meets the injury element if they prove the unlawful conduct diminished a business or property interest, even if the injury is minimal. Panag, 166 Wn.2d at 57. Unquantifiable damages, such as loss of goodwill or delay in receiving money, may also satisfy the element. Panag, 166 Wn.2d at 58. When the claimed injury is the payment of money, "The issue is whether the plaintiff was wrongfully induced to pay money on a debt not owed or to incur expenses that would not otherwise have been incurred." Panag, 166 Wn.2d at 62 (internal quotation omitted).

Again, viewing the evidence in the light most favorable to the Hamakers, HD's lien practices caused them to pay for certain medical bills out of their

[9] The Hamakers correctly note in their briefing that under Washington law standing is not a separate requirement for demonstrating a valid CPA claim. See Panag v. Farmers Ins. Co. of Wash., 166 Wn.2d 27, 37-38, 204 P.3d 885 (2009). The trial court granted summary judgment to Highline based on a lack of standing. But presumably, the trial court determined the CPA claim failed to meet the injury element; the court stated its primary concern was injury.

settlement instead of having their insurance pay for them. Thus, when viewing the evidence in the light most favorable to the Hamakers, they demonstrated they incurred costs they otherwise would not have. This raises a genuine issue as to whether the Hamakers suffered an injury under the CPA.[10]

Because the Hamakers demonstrated HD's lien practices raised a genuine issue as to whether they suffered an injury as to both the non-CPA and CPA claims, we reverse the trial court's order granting summary judgment for Highline and denying partial summary judgment and class certification for the Hamakers. Because the trial court based its decisions solely on its conclusion that plaintiffs lacked standing and failed to raise an issue of fact as to injury—and this opinion limits its discussion to only those issues—our reversal is without prejudice as to other arguments raised by the parties in their motions below.

Reversed.

Chun, J.

WE CONCUR:

Andrus, J.

Leach, J.

[10] Because we determine the Hamakers' payment to Highline constituted an injury under the CPA, we do not address their other theories of injury.

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION ONE

PAUL HAMAKER, individually and as a putative class representative, and JOSEPHINE HAMAKER, individually and as a putative class representative,

Appellant,

v.

HIGHLINE MEDICAL CENTER, a Washington non-profit corporation,

Respondent,

REBECCA A. ROHLKE, individually, on behalf of the marital community and as agent of non-party Hunter Donaldson; JOHN DOE ROHLKE, on behalf of the marital community; RALPH WADSWORTH, individually, on behalf of the marital community, and as agent of nonparty Hunter Donaldson, JANE DOE WADSWORTH, on behalf of the marital community; TIM CARDA, individually, on behalf of the marital community, and as agent of non-party Hunter Donaldson, JANE DOE CARDA, on behalf of the marital community; GRACIELA PULIDO, individually, on behalf of the marital community and as agent of non-party Hunter Donaldson, JOHN DOE PULIDO, on behalf of the marital community, KIMBERLY WADSWORTH, individually, on behalf of the marital community and as agent of nonparty Hunter Donaldson, and JOHN DOE WADSWORTH, on behalf of the marital community,

Defendants.

No. 77578-2-I

ORDER DENYING MOTION FOR RECONSIDERATION

The respondent, Highline Medical Center, has filed a motion for reconsideration. A panel of the court has determined that the motion should be denied.

Now, therefore, it is hereby

ORDERED that the motion for reconsideration is denied.

Chun, J.

Judge

FAVROS LAW

May 20, 2019 - 4:06 PM

Transmittal Information

Filed with Court:	Court of Appeals Division I
Appellate Court Case Number:	77578-2
Appellate Court Case Title:	Paul Hamaker & Josephine Hamaker, Appellants v. Highline Medical Center, Respondent
Superior Court Case Number:	16-2-02870-5

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