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

SCOTTSDALE MEMORIAL HEALTH SYSTEMS, INC.; AIR EVAC SERVICES, INC.; ARROWHEAD COMMUNITY HOSPITAL; CHANDLER REGIONAL HOSPITAL; COBRE VALLEY COMMUNITY HOSPITAL; CRITICAL AIR MEDICINE; DESERT SAMARITAN MEDICAL CENTER; GOOD SAMARITAN MEDICAL CENTER; FLAGSTAFF MEDICAL CENTER; JOHN C. LINCOLN HOSPITAL; LUTHERAN HEART HOSPITAL; MESA GENERAL HOSPITAL; MESA LUTHERAN HOSPITAL; NAVAPACHE REGIONAL MEDICAL CENTER; NORTHWEST MEDICAL CENTER; PAYSON REGIONAL MEDICAL CENTER; PHOENIX BAPTIST HOSPITAL; PHOENIX CHILDREN'S HOSPITAL; SCOTTSDALE HEALTHCARE - OSBORN; SCOTTSDALE HEALTHCARE - SHEA; ST. JOSEPH'S HOSPITAL; ST. JOSEPH'S TRAUMA; ST. LUKE'S BEHAVIORAL HEALTH; ST. LUKE'S HOSPITAL; TEMPE ST. LUKE'S HOSPITAL; THUNDERBIRD SAMARITAN MEDICAL CENTER; VALLEY LUTHERAN HOSPITAL; VERDE VALLEY MEDICAL CENTER; WESTERN ARIZONA REGIONAL MEDICAL CENTER, Plaintiffs-Appellees, v. MARICOPA COUNTY, a political subdivision of the State of Arizona, Defendant-Appellant.	1 CA-CV 07-0150 1 CA-CV 08-0241 1 CA-CV 08-0344 (Consolidated) DEPARTMENT D **MEMORANDUM DECISION** (Not for Publication – Rule 28, Arizona Rule of Civil Appellate Procedure)

SCOTTSDALE MEMORIAL HEALTH SYSTEMS, INC.; AIR EVAC SERVICES, INC.; ARROWHEAD COMMUNITY HOSPITAL; CHANDLER REGIONAL HOSPITAL; COBRE VALLEY COMMUNITY HOSPITAL; CRITICAL AIR MEDICINE; DESERT SAMARITAN MEDICAL CENTER; GOOD SAMARITAN MEDICAL CENTER; FLAGSTAFF MEDICAL CENTER; JOHN C. LINCOLN HOSPITAL; LUTHERAN HEART HOSPITAL; MESA GENERAL HOSPITAL; MESA LUTHERAN HOSPITAL; NAVAPACHE REGIONAL MEDICAL CENTER; NORTHWEST MEDICAL CENTER; PAYSON REGIONAL MEDICAL CENTER; PHOENIX BAPTIST HOSPITAL; PHOENIX CHILDREN'S HOSPITAL; SCOTTSDALE HEALTHCARE - OSBORN; SCOTTSDALE HEALTHCARE - SHEA; ST. JOSEPH'S HOSPITAL; ST. JOSEPH'S TRAUMA; ST. LUKE'S BEHAVIORAL HEALTH; ST. LUKE'S HOSPITAL; TEMPE ST. LUKE'S HOSPITAL; THUNDERBIRD SAMARITAN MEDICAL CENTER; VALLEY LUTHERAN HOSPITAL; VERDE VALLEY MEDICAL CENTER; WESTERN ARIZONA REGIONAL MEDICAL CENTER,	)
Plaintiffs-Appellants/ Cross-Appellees,	)
v.	)
MARICOPA COUNTY, a political subdivision of the State of Arizona,	)
Defendant-Appellee/ Cross-Appellant.	)

Appeal from the Superior Court in Maricopa County

Cause Nos. CV1997-021512, CV1998-000759, CV1998-002035, CV1998-008011, CV1998-010714, CV1998-011303, CV1998-013574, CV1998-016162, CV1998-022632, CV1999-008827 (Consolidated)

The Honorable F. Pendleton Gaines, III, Judge

REVERSED AND REMANDED

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PER CURIAM

¶1 At issue in these consolidated appeals are thousands of claims by hospitals (the Hospitals) against Maricopa County (the County) under statutes that provided for reimbursement of fees incurred in providing emergency treatment to indigent residents of the County. Because of the large number of claims and the many statutory criteria required for reimbursement, these cases presented a tremendous case-management problem. Ultimately, the superior court entered judgment in the Hospitals' favor based on a Special Master's findings.

¶2 In a separate Opinion, issued contemporaneously with this decision, we reverse and remand the judgments for the reasons stated therein. In this memorandum decision, we address issues the parties have raised concerning the legal standards

for claim evaluation that will be relevant on remand. Because our analysis in this decision involves the interpretation of statutes that have been repealed, it is not appropriate for publication.

FACTS AND PROCEDURAL HISTORY

¶3 In 1981, the Arizona legislature shifted primary responsibility for indigent health care from Arizona's counties to the State through the implementation of the Arizona Health Care Cost Containment System (AHCCCS), which provides health care benefits to persons meeting certain statutory criteria. Arizona Revised Statutes (A.R.S.) sections 11-290 through 11-305 (1997) and sections 36-2091 through 36-2929 (2003 & Supp. 2008). Under this statutory scheme, counties retained responsibility to provide health care to indigent patients not enrolled in AHCCCS. A.R.S. §§ 11-291 and 36-2903(A), (B). The Hospitals filed hundreds of individual claims in the trial court seeking payment from the County for indigent health care services. These claims were consolidated into one case, Maricopa County Cause Number CV1997-021512. The consolidated cases were divided into twenty-seven "Cycles," which involved claims arising before September 1999. The parties settled Cycle 1, and tried Cycles 2 and 3

(Cycles 2/3 case) to the court.[1] The remaining Cycles were tried together (the Cycles phase).

¶4 Claims for medical services rendered after October 1, 1999, were subject to a new resolution process enacted by the legislature. A.R.S. § 11-297.03 (1999) (repealed 2001). Section 11-297.03(A) required the County to establish a resolution procedure for disputed claim denials and required the County and health care providers to make a good faith effort to resolve such claims. The Hospitals submitted claims to the County in accordance with this statute. On February 28, 2003, the Hospitals filed a mandamus action against the County seeking an order compelling the County to conclude the claims resolution process, Maricopa County Cause Number LC2003-00173-001-DT. The dispute was settled by the parties' agreement that the statutory claims resolution process ended on June 23, 2004. Pursuant to the parties' agreement, the Hospitals dismissed the mandamus action with prejudice and filed an amended complaint seeking judicial resolution of the claims not resolved during the statutory claims resolution process. Those claims were referred to the Special Master and tried separately (the Claims Resolution phase) from the Cycles phase.

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[1] We addressed the County's appeal from the judgment in the Cycles 2/3 case in our opinion in *John C. Lincoln Hosp. & Health Corp. v. Maricopa County*, 208 Ariz. 532, 96 P.3d 530 (App. 2004).

¶5 The Hospitals then initiated several lawsuits seeking judicial resolution of claims raised after the termination of the claims resolution process.[2] Those claims were referred to the Special Master and tried separately (the Post-Claims Resolution phase) from the Cycles phase and the Claims Resolution phase.

DISCUSSION

A. Eligibility Standards.

¶6 In all three trials, the Hospitals sought reimbursement pursuant to former A.R.S. § 11-297.01(B) (1997 & 1999) (repealed 2001).[3] Section 11-297.01(B) required the County to reimburse private hospitals and other health care providers that provided emergency medical care to indigent County residents.[4] To obtain reimbursement the Hospitals were required to prove: (1) the patient was a resident of Maricopa County; (2) the patient qualified as "indigent" under the statutory definition; and (3) the Hospitals rendered emergency medical

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[2] The lawsuits were Maricopa County Cause Numbers CV2001-013916, CV2001-013917, CV2001-013936, CV2001-013937, CV2002-002745, CV2002-022447, CV2004-001586.

[3] Claims in the Cycles and Claims Resolution trials were brought under the 1997 version of the statute, and claims in the Post-Claims Resolution trial were brought under the 1999 amended version.

[4] The statute also imposed certain notice requirements discussed *infra* ¶ 37.

services to the patient. A.R.S. § 11-297.01(A)-(C).[5] On each of the sample claims on which the Hospitals prevailed at trial, the Special Master determined that the Hospitals carried their burden of proof on each of these required elements. The County challenges many of these decisions on appeal. In this memorandum decision, we set forth the legal standards applicable to these elements to guide the parties and the court on remand.

1. Residency.

¶7 Residency is "primarily a state of mind combined with actual physical presence" in the county. *St. Joseph's Hosp. & Med. Ctr. v. Maricopa County*, 142 Ariz. 94, 99, 688 P.2d 986, 991 (1984) (citation omitted). Arizona courts have historically applied a subjective test, asking whether a person is in the county to "reside permanently, and who, at least for the time being, entertains no idea of having or seeking a permanent home elsewhere." *Id*. (citation omitted). For purposes of determining residency, a person's intent is judged not only by his statements, but also by his conduct and the surrounding circumstances. *Kocher v. Dep't of Revenue of State of Ariz.*, 206 Ariz. 480, 483, ¶ 12, 80 P.3d 287, 290 (App. 2003) (citation and internal quotation omitted). The question of intent is

[5] The residency requirement was contained in A.R.S. § 11-297.C.1 (1999). The 1997 version of this statute was identical.

therefore one of fact. *Webster v. State Bd. of Regents*, 123 Ariz. 363, 367, 599 P.2d 816, 820 (App. 1979).

¶8 To prevail on this element, the Hospitals were required to offer evidence that the patient whose treatment gave rise to a particular claim was a County resident at the time of treatment. Documentation of a local address for the patient, a statement from the patient that he or she lived in the County and intended to stay in the County, and circumstantial evidence of employment or AHCCCS eligibility before or immediately after the time of treatment are examples of the type of evidence that could be sufficient to support a finding of residency.[6] However, a statement by the patient at the time of treatment that he did not intend to remain in the County or the absence of information regarding the patient's residence could preclude a finding of residency. For example, an award on a claim for treatment of an unidentified patient who was unconscious throughout his treatment and for whom there was no evidence of residency would be clearly erroneous because there would be nothing on which the Special Master could base a finding that the patient was a County resident at the time of treatment. On the other hand,

[6] Evidence that a patient may have been an undocumented immigrant would not alter the residency determination. *St. Joseph's Hosp. & Med. Ctr.*, 142 Ariz. at 98, 688 P.2d at 990. It may, however, have otherwise limited the County's obligation to pay for that patient's care. *See* former A.R.S. § 11-297(B)(5).

absent evidence of a contrary intent, a homeless person admitted for treatment might be found to be a resident of the County based simply on his presence in Maricopa County.

2. Financial eligibility.

¶9 At the time the claims at issue arose, Arizona law provided that hospitals were entitled to reimbursement from the County for emergency care provided to indigent patients. Former A.R.S. §§ 11-297(A)-(B) and 11-297.01(B). An indigent was defined as a person whose annual income or assets did not exceed statutory limits. Former A.R.S. § 11-297(B)(1) & (B)(2) (1997).

a. Assets.

¶10 To meet the statutory definition of "indigent" under A.R.S. § 11-297(B)(2), a patient's household net worth could not exceed $50,000, including equity in a house or vehicle, and the patient could have no more than $5000 in cash or other liquid assets. To prove indigency, the Hospitals were required to offer some evidence of the patient's assets at the time of treatment. Naturally, uncontradicted evidence that a patient's assets exceeded the statutory limit would preclude a finding that the patient was indigent. However, direct or circumstantial evidence that the patient's assets did not exceed the statutory limit could support a finding of indigence. Therefore, a patient's statement that he did not have any assets, or that the value of his assets did not exceed the

statutory limit, could support a finding of indigence, as would tangible evidence showing the patient's assets were valued at less than the statutory limits.

¶11 At trial, the Hospitals relied on numerous provisions of the Maricopa County Department of Health Services Eligibility Policy and Procedure Manual (the Manual) that prescribed which assets should be considered or disregarded when determining indigence. In particular, the Hospitals cited provisions from the Manual regarding the treatment of assets of a patient's unmarried parents, a child's sole and separate income (such as Social Security income, child support payments, and earned income), loan proceeds and retirement accounts. The County did not dispute the existence or relevance of these regulations and cited no rule or law providing that the Manual should not govern. We hold that as long as the provisions of the Manual do not conflict with the statutes creating County liability, it is appropriate to refer to those provisions to determine which assets to consider when determining indigence.

¶12 At trial, the parties also disputed the relevant date for the valuation of a patient's assets. In *Walter O. Boswell Memorial Hosp. Inc. v. Yavapai County*, 148 Ariz. 385, 387, 714 P.2d 878, 880 (App. 1986), we determined that the relevant date for calculating eligibility was the "date of application." Accordingly, we hold that the relevant date for determining

eligibility based on net worth and liquid assets is the date(s) hospital services are provided.

b. Income.

¶13 For a patient to meet the statutory definition of "indigent" under A.R.S. § 11-297(B)(1)(a), his or her annual income could not exceed $2500.[7] Annual income was calculated by multiplying the patient's income for the three months immediately before treatment, by four. Former A.R.S. § 11-297(B).

¶14 Again, the Hospitals were required to present evidence of each patient's income or lack of income. Evidence that the patient was unemployed or, if employed, that his wages did not exceed the statutory limitation, could support a finding of indigence. However, the absence of evidence regarding whether the patient was employed or the amount of his wages would preclude a finding that the patient was indigent. Therefore, an award on a claim for treatment of a patient who said he was self-employed but who did not disclose the amount of his income would be clearly erroneous because there would be no evidence the patient's income did not exceed the statutory limit. Circumstantial evidence of a patient's wages or lack of wages, such as those found in records maintained by the Arizona

[7] The statute provided a greater income limit for a patient living with a spouse or with one or more dependents. Former A.R.S. § 11-297(B)(1)(a)-(c).

Department of Economic Security (DES), could support a finding that the patient qualified as indigent unless rebutted by other evidence that the patient had income not reported to DES.

c. Spend-down.

¶15 Arizona law provided that medical expenses incurred by a patient in the twelve months immediately before the determination of indigence, and for which he was liable, were to be deducted from the patient's income before determining indigency. Former A.R.S. § 11-297(E)(1). We have held that this "spend-down" amount is not limited to medical expenses the patient *paid* in the year prior to the claim at issue, but rather includes all medical expenses *incurred* by the patient during that period. *Boswell*, 148 Ariz. at 390, 714 P.2d at 883. Accordingly, a patient who did not qualify as indigent at the time emergency treatment began could nevertheless become indigent during hospitalization by incurring hospital and medical charges. *John C. Lincoln*, 208 Ariz. 532, 536 n.2, ¶ 7, 96 P.3d 530, 534 n.2 (App. 2004).

¶16 The County argues on appeal that the Special Master improperly applied an assumption in the Claims Resolution phase that each patient had incurred non-hospital medical costs equal to a set percentage of hospital charges, rather than requiring evidence of such medical costs. The Special Master applied a 25% doctor-bill spend-down assumption to claims arising before

May 2000, in accordance with our holding in *John C. Lincoln*. In *John C. Lincoln*, we held that the County was equitably estopped from contesting a 25% doctor-bill spend-down assumption as to "patient claims arising before May 2000, when the [County] informed the Hospitals it would no longer settle contested claims and instead opt for litigation." 208 Ariz. at 538, ¶ 13, 96 P.3d at 536. The parties in *John C. Lincoln* had earlier agreed that a 25% assumption would apply to claims they settled. *Id.* at 537, ¶ 11, 96 P.3d at 535. In the Claims Resolution phase, the Special Master applied a 15% assumption to claims arising after May 1, 2000, based on the County's evidence of the average patient's non-hospital charges.

¶17 In the Claim Resolution joint pretrial statement, the County listed among the contested issues of fact it deemed material, "whether the 25% non-hospital bill assumption is reasonable and supported by reliable data." Thus, rather than assert that no spend-down assumption should be applied, the County disputed the size of the spend-down assumption. Moreover, it was the County that provided evidence that the average non-hospital bill amount was 15% of the hospital bill. Therefore, the County waived any argument against applying a spend-down assumption. The Special Master correctly applied the 25% spend-down assumption to claims before May 1, 2000, and the

evidence supported his application of a 15% assumption to claims after that date.

¶18 We also reject the County's argument that the Special Master improperly allowed amounts as "prior medical expenses" that were related to the treatment as issue, because the County does not identify any specific claims in which this alleged error occurred. ARCAP 13(a)6; *Adams v. Valley Nat'l Bank of Ariz.*, 139 Ariz. 340, 343, 678 P.2d 525, 528 (App. 1984) ("We are not required to assume the duties of an advocate and search voluminous records and exhibits to substantiate an appellant's claims.").

¶19 The County further contends that in the Post-Claims Resolution trial, the Special Master improperly included within the medical-expense spend-down amounts recovered by the Hospitals through liens filed against third-party payments to patients. We find it helpful to consider this issue in light of a hypothetical: Once a patient whose income exceeds the statutory limit for indigence by $7500 incurs $7500 in hospital charges, he becomes indigent for purposes of this analysis and, thereafter, the County is responsible for the cost of his emergency medical care. *John C. Lincoln*, 208 Ariz. at 536 n.2, ¶ 7, 96 P.3d at 534 n.2. This is true whether or not the patient actually pays the $7500 hospital charge. *Boswell*, 148 Ariz. at 390, 714 P.2d at 883. But suppose the patient later

recovers a judgment of $7500 against a third-party tortfeasor, and the hospital attaches the judgment. The County argues that in this example the $7500 in hospital charges should not be attributed to the patient's "spend-down" for purposes of determining indigence. We disagree.

¶20 As noted, medical charges incurred by a patient are included within the patient's spend-down, regardless of whether the patient pays those expenses. *Id.* That being the case, we see no reason to apply a different rule in the case of medical expenses that the patient "pays" to a hospital that attaches a lien on a judgment the patient receives from a third-party tortfeasor.[8]

¶21 We reject the County's argument that *Lizer v. Eagle Air Med. Corp.*, 308 F. Supp. 2d 1006 (D. Ariz. 2004), prohibits the Hospitals' lien recoveries. In that case, Lizer was injured in a vehicle collision and transported to a hospital by Eagle Air's air ambulance service. *Id*. at 1007. Lizer was an eligible participant of AHCCCS, which paid Eagle Air $4,827.68 of its $22,415 bill for Lizer's transport. *Id*. Thereafter,

[8] The County argues that the Hospitals were statutorily required by A.R.S. § 11-291(A) (2000) to apply any third-party recoveries to reduce the County's liability. That statute, however, provided that a county was obliged to provide medical care to indigent residents, "to the extent that such expenses are not *covered* by a third party payor [or AHCCCS]." (Emphasis added.) However, that exclusion applies only to medical care provided to county prisoners. *Id.*

Lizer recovered $41,710 from his insurance carrier. *Id*. Eagle Air filed a lien against the insurance recovery for the total amount of its bill, $22,415. *Id*. Lizer argued federal law prevented Eagle Air from enforcing its lien because it required Arizona to compel AHCCCS providers to agree to accept the amounts paid by AHCCCS as payment in full. *Id*. at 1009. The court noted that in compliance with federal law, Arizona law required that "once a provider accepts a payment from AHCCCS on behalf of an individual, the provider may not attempt to collect the unpaid balance of the bill directly from that individual." *Id*. However, Arizona courts had not interpreted this provision to prevent a provider from placing a lien on lawsuit or settlement proceeds. *Id*. The district court held that such a construction violated the purpose of the federal statute, which it wrote was intended to prevent providers from "billing *any* entity for the difference between their customary charge and the amount paid by [AHCCCS]." *Id*. The court ruled Eagle Air could not assert a lien against Lizer's insurance proceeds for the balance of his bill. *Id*. at 1010.

¶22 The court in *Lizer* did not prohibit all lien recoveries, but only prohibited liens which allowed a provider to recover from a patient that portion of its bill not paid by AHCCCS. Unlike the balance billing at issue in *Lizer*, in this case, the Hospitals filed the liens to recover the amounts owed

by the patients to the Hospitals, charges the patients incurred before they had "spent down" their income and qualified for County coverage. The County cites no prohibition, and we find none in *Lizer*, against lien recovery for those charges. So long as the patient has received the credit against his income for *incurring* the debt to the hospital, there is no effect on the indigency determination if the debt is later paid through a lien or otherwise.

¶23 Finally, the County complains that in the Post-Claims Resolution trial, the Hospitals were allowed to add 25% to patients' prior medical expenses for purposes of calculating the spend-down.[9] The Hospitals argue that this issue was resolved in *John C. Lincoln* and the County cannot re-litigate it. The County protests that the ruling in *John C. Lincoln* concerned only expenses related to the "care in question," whereas the assumption in the Post-Claims Resolution trial pertained to medical expenses incurred in the twelve months before the "care in question." While we did not address this precise issue in *John C. Lincoln*, the County is precluded from raising this argument because it failed to raise it on appeal in that case. *Torrez v. Knowlton*, 205 Ariz. 550, 552 n.1, ¶ 3, 73 P.3d 1285, 1287 n.1 (App. 2003) (stating issues not argued on appeal are

[9] Before May 2000, the parties made an assumption, for the purpose of settling cases, related non-hospital expenses for a patient approximated 25% of the settled hospital bill.

deemed abandoned); *Robert Schalkenbach Found. v. Lincoln Found. Inc.*, 208 Ariz. 176, 180-81, ¶¶ 18-20, 91 P.3d 1019, 1023-24 (App. 2004) (holding issue preclusion applied where previous final judgment was entered and not appealed).

¶24 During the Cycles trial, the Hospitals explained that they had applied the 25% spend-down assumption to prior medical expenses in calculating indigency in the Cycles 2/3 case. After the Hospitals prevailed in that case, the County did not raise the issue in its appeal. Collateral estoppel applies "when the issue sought to be precluded is the same as that involved in the prior proceeding, the issue was actually litigated in the prior proceeding, the issue was determined by a valid and final judgment on the merits, and the determination was essential to the final judgment." *Corbett v. ManorCare of Am., Inc.*, 213 Ariz. 618, 624, 146 P.3d 1027, 1033 (App. 2006) (citation omitted). This is true whether the issue previously decided is one of fact or law. Restatement (Second) of Judgments § 27 (1982). "Whether a ruling is essential must be determined on a case-by-case basis." *Garcia v. Gen. Motors Corp.*, 195 Ariz. 510, 514, ¶ 10, 990 P.2d 1069, 1073 (App. 1999); *see also Collins v. Miller & Miller Ltd.*, 189 Ariz. 387, 397, 943 P.2d 747, 757 (App. 1996) (finding that previous rulings were not essential to judgment when "those issues were only incidentally decided and the court's statements in connection with those

issues had no bearing on the principal ground on which the court dismissed the lawsuit").

¶25 In this case, because these calculations were essential to the judgment in the Cycles 2/3 case and the County did not contest them in that appeal, the County is precluded from raising the issue in these cases. The inclusion of these calculations was, therefore not error.

3. Emergency treatment.

¶26 Arizona law required the County to provide emergency care to indigent County residents "when immediate hospitalization or medical care is necessary for the preservation of life or limb." Former A.R.S. § 11-297(A). The County also was required to reimburse private hospitals or other health care providers when they rendered emergency treatment and medical care to an indigent County resident. Former A.R.S. § 11-297.01(B).

¶27 The County asserted at trial that it was liable only for treatment of an "emergency medical condition" as that term applies to emergency care provided pursuant to AHCCCS to undocumented immigrants. *See* A.R.S. § 36-2903.03 (1997). Relying on A.R.S. § 36-2903.03, the County argued that "emergency medical condition" means:

> a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that

> the absence of immediate medical attention could reasonably be expected to result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment of bodily functions; or (c) serious dysfunction of any bodily organ or part.

In contrast, the Hospitals urged the Special Master to allow coverage of all medical expenses necessary to preserve the patient's "health, life or limb," citing *Thompson v. Sun City Cmty. Hosp. Inc.*, 141 Ariz. 597, 603, 688 P.2d 605, 611 (1984) and A.R.S. § 41-1831(7) (2004) ("'Emergency medical patient' means a person who is suffering from a condition which requires immediate medical care or hospitalization, or both, in order to preserve the person's health, life or limb."). In *Thompson*, our supreme court relied on that statutory definition in determining whether emergency care was medically indicated, such that a private hospital was required by law to provide it. 141 Ariz. at 603, 688 P.2d at 611.

¶28 We hold that the correct definition to apply in these cases is the one contained in the law that governed emergency care of indigent patients at private hospitals for which the County was responsible, former A.R.S. § 11-297.01(B). The standard is prospective, not retrospective. *Samaritan Health Servs. v. AHCCCS*, 178 Ariz. 534, 538-39, 875 P.2d 193, 197-98 (App. 1994) (holding AHCCCS cannot refuse to pay for emergency transportation based on its retrospective view that attending physician's determination that emergency existed was incorrect).

To support a claim, a hospital must offer evidence that the care rendered was emergency care necessary for the preservation of life or limb. The fact that the care was administered in an emergency room, without more, is not sufficient to satisfy this burden.

4. Medical review.

¶29 The County contends the Special Master improperly granted reimbursement in the Claims Resolution trial when the care given by the Hospitals was not the "most appropriate, most cost-effective, and [in the] least restrictive setting," as required by statute. Former A.R.S. § 11-297.02(F)(3)(c)(1999) (repealed 2001).[10] As the County was not liable for any claim that did not satisfy this criterion under former A.R.S. § 11-297.02(A), the Hospitals were required to show for each claim at issue that the services were provided in the most appropriate, most cost-effective, and least restrictive setting. Evidence regarding the nature of the treatment, along with evidence of the absence of less costly or less restrictive alternative care, may satisfy this burden.

B. Notice.

¶30 Section 11-297.01(C) provided that to recover the costs of emergency treatment for an indigent patient, a hospital

[10] The parties resolved this issue pursuant to stipulation in the Post-Claims Resolution trial.

must give the County "oral or written notice of the location, name, address and condition of the patient within twelve hours after the time the patient is admitted for treatment." A hospital was relieved of this burden only if it "demonstrate[d] that the patient or another person acting on behalf of the patient submitted evidence of insurance coverage" that was later deemed to be invalid and it retained documentation of that evidence. *Id*. If a hospital failed to give timely notice, it was entitled to payment only for treatment rendered to the patient from the time notice was actually given. *Id*.

1. No notice.

a. In-Patient accounts.

¶31 The County contends the Special Master erroneously granted several claims in the Cycles trial even though the Hospitals did not properly notify the County of the patient.[11] The Hospitals do not contest this argument on appeal, and do not cite, nor do we find, any evidence in the record that they notified the County of these patients. Accordingly, the Special Master's award of these claims to the Hospitals was clearly erroneous.

[11] The County specifically identified Juan P. (Maryvale), Kristin S. (Good Samaritan), Houren H. (Phoenix Baptist), Javier A. (Thunderbird) and Korion H. (Good Samaritan). The County did not challenge the claim for Bryan C. (Good Samaritan) in the Cycles phase on the basis of lack of notification, and we do not consider it for the first time on appeal. *Trantor v. Fredrikson*, 179 Ariz. 299, 300, 878 P.2d 657, 658 (1994).

b. Treat-and-release patients.

¶32 Treat-and-release patients are treated in a hospital emergency room and released without being admitted as in-patients. The Hospitals argue, and the Special Master concluded, that the County did not require notice of treat-and-release patients and therefore was estopped to assert that the statutory notice requirement applied to them.

¶33 Assuming without deciding that the Hospitals were required by law to give notice of treat-and-release patients, the Special Master did not abuse err in determining that the County was equitably estopped from asserting the statutory notice requirement applied to those patients. To "establish equitable estoppel, a party must show: (1) affirmative acts inconsistent with a claim afterwards relied upon; (2) action by a party relying on such conduct; and (3) injury to the party resulting from a repudiation of such conduct." *John C. Lincoln*, 208 Ariz. at 537, ¶ 10, 96 P.3d at 535. This is a fact-intensive inquiry, and we will not reverse a trial court's determination unless it is clearly erroneous. *Id*.

¶34 The Hospitals presented evidence that through the end of 1997, the County never provided a written policy requiring notice for treat-and-release patients and indeed told the

Hospitals not to give notice of treat-and-release patients.[12] The County did not assert lack of notice for treat-and-release patients as a defense to claims for treatment before April 14, 1998, but contends it changed that policy in a letter dated April 14, 1998, and that the Hospitals were not entitled to rely on alleged, contrary oral instructions. *See id.* at 537, ¶ 11, 96 P.3d at 535 (stating that when applied to an action by a government, the requirement of an affirmative act inconsistent with a later position requires a "considerable degree of formalism").

¶35 We agree with the Hospitals that the April 14, 1998 letter, addressed to a third-party not involved in this litigation, is not sufficient evidence that the County changed its policy to begin to require notice of treat-and-release patients. This is especially true when coupled with the undisputed oral representations of County employees that notice was not required. The remaining elements of reasonable and detrimental reliance are undisputed: because the County represented it did not require notice for these patients, the Hospitals did not notify the County within the statutory time period when they treated these patients and cannot now do so. Therefore, the Special Master's determination that the County is

[12] The Hospitals' witness acknowledged, however, that the County denied treat-and-release claims on the basis of lack of notice.

equitably estopped from asserting lack of notice for treat-and-release claims is not clearly erroneous.[13]

2. Late notice.

a. Amount of reimbursement.

¶36 The notice provision contained in A.R.S. § 11-297.01(C) (1997) (repealed 2001) stated that if a hospital failed to notify the County of a patient within twelve hours "after the time the patient is admitted for treatment," the hospital only would be "entitled to payment from the county for treatment which is rendered to the patient from the time notice is actually given to the county until the time the patient is discharged or transferred to another facility." The County complains the Special Master improperly granted claims in such cases that included charges incurred before the time the Hospitals notified the County of the patient. It contends that because the statute refers to the "time" of notice, rather than the "day" or "date" of notice, the Special Master erred by granting reimbursement to the Hospitals for services not shown to have been rendered after the time of notice.

[13] We do not believe that estoppel, applied in this case, will "'substantially and adversely affect the exercise of government powers,'" because the County elected not to implement a written policy requiring the Hospitals to adhere to the statutory notice requirements. *John C. Lincoln*, 208 Ariz. at 538, ¶ 14, 96 P.3d at 536 (citation omitted). Rather than issue a written directive to the Hospitals requiring notice of all emergency patients, the County allowed its employees to provide inconsistent information upon which the Hospitals relied.

¶37 The County cites the trial court's decision in the Cycles 2/3 case granting summary judgment to the County on this issue and ruling that its asserted practice of paying all charges incurred on the day of notice was irrelevant given the strict mandates of former A.R.S. § 11-297.01(C). It argues the Hospitals were barred by the doctrine of collateral estoppel from asserting claims for which they did not show the charges were incurred after the time of notice. In response, the Hospitals argue that the ruling in the Cycles 2/3 case was not preclusive because it was not essential to the judgment in that case.

¶38 As previously stated, collateral estoppel applies "when the issue sought to be precluded is the same as that involved in the prior proceeding, the issue was actually litigated in the prior proceeding, the issue was determined by a valid and final judgment on the merits, and the determination was essential to the final judgment." *Corbett*, 213 Ariz. at 624, 146 P.3d at 1033.

¶39 In the Cycles 2/3 case, the court ruled that the County was obliged to pay only for treatment rendered after the time of notice. In its ruling, the court also rejected the Hospitals' argument that the County was bound by its long-standing practice of paying all charges incurred on the day of notice. The Hospitals acknowledge that at least one of the five

claims that was the subject of the County's summary judgment motion in the Cycle 2/3 case was ultimately determined at trial and included in the final judgment. The summary judgment ruling was therefore subject to review in the Cycles 2/3 case, but the Hospitals did not appeal that ruling. Accordingly, collateral estoppel applies and the Special Master erred by awarding the full amount of the thirty-three claims identified by the County on appeal as subject to this rule.

b. Evidence-of-insurance exception.

¶40 A hospital may be relieved of its obligation to notify the County of its treatment of an indigent patient only if it demonstrated that the patient submitted evidence of insurance coverage that was later deemed to be invalid. Former A.R.S. § 11-297.01(C). The County contends the Special Master improperly granted claims to the Hospitals in the Cycles phase for which they neither timely notified the County nor offered any proof that the patient submitted evidence of insurance at the time of treatment. The County argues the statutory "evidence-of-insurance" exception applies only when the Hospitals produce "documentary evidence of current insurance coverage such as a facially valid insurance card," and contends a patient's "uncorroborated verbal statement" does not suffice as evidence of insurance that would excuse the Hospitals from their notification obligation. We disagree.

¶41 The statute relieved a hospital of its obligation to notify the County of an indigent patient if: (1) the hospital demonstrated that the patient submitted evidence of insurance coverage that was later deemed to be invalid, and (2) it retained documentation of that evidence. Former A.R.S. § 11-297.01(C). The statute did not require the patient present any specific form of evidence of insurance coverage, and, in particular, did not require that the evidence be in "documentary" form. *Id.* Under the plain language of the statute, a patient's oral representation that he or she had insurance coverage, when that representation was noted in writing by a hospital, was adequate to relieve the HospitalS of its obligation to notify the County within twelve hours of the patient's admission for treatment.[14] *See Bilke v. State*, 206 Ariz. 462, 464, ¶ 11, 80 P.3d 269, 271 (2003) (reasoning that a statute's unambiguous language controls).

3. Doctor Claims.

¶42 The County complains the Special Master erroneously granted reimbursement for services rendered by physicians and emergency transport even though it was undisputed that no notice was given when those services were provided.

[14] Given the clear statutory requirement, it is not necessary to consider the County's evidence regarding the Hospitals' internal practices of insurance documentation.

¶43 The County urges us to construe former A.R.S. § 11-297.01(C) to require notice from physicians as well as hospitals, citing *Perez v. Maricopa County*, 158 Ariz. 40, 41, 760 P.2d 1089, 1090 (App. 1988). In that case, we discussed an earlier version of A.R.S. § 11-297.01(B) under which a county was liable for payment of costs incurred by private or university hospitals in the emergency treatment of indigent patients. *Id*. We found no reason to distinguish between care provided by hospital employees and that provided by independent physicians and construed the statute to require reimbursement of emergency physicians' fees for treatment of indigent patients. *Id*.

¶44 The County notes that the statutory language at issue in *Perez* and in this case is identical ("a private hospital or hospital operated by a university") and urges us to follow *Perez* and construe the language broadly to encompass both hospitals and physicians. However, as we noted in *Perez*, the legislature subsequently amended A.R.S. § 11-297.01(B) to explicitly provide licensed health care providers a right of reimbursement for their costs incurred in emergency treatment of indigent patients. *Id*. The legislature did not impose on these health care providers a corresponding obligation to give notice, and we decline to read one into the statute. *City of Phoenix v. Donofrio*, 99 Ariz. 130, 133, 407 P.2d 91, 93 (1965) (citation

omitted) ("[C]ourts will not read into a statute something which is not within the manifest intention of the legislature as gathered from the statute itself.").

¶45 Accordingly, we reject the County's argument that physicians and emergency transportation companies were required to notify the County of their treatment of indigent patients under A.R.S. § 11-297.01(C).

C. Other Legal Determinations.

1. Recoupment.

¶46 The County contends the Special Master erred as a matter of law by denying its claims for recoupment of certain amounts it contends it paid to the Hospitals in error. "[A] recoupment is a reduction by the defendant of part of the plaintiff's claim because of a right in the defendant arising out of the same transaction." *Morris v. Achen Constr. Co.*, 155 Ariz. 507, 510, 747 P.2d 1206, 1209 (App. 1986), *rev'd and vacated on other grounds*, 155 Ariz. 512, 747 P.2d 1211 (1987) (citation omitted). "Recoupment is an equitable doctrine" that may "be used to reduce or eliminate a judgment, but it cannot be used for purposes of affirmative relief." *State ex rel. Ariz. Dep't of Rev. v. Capitol Castings Inc.*, 193 Ariz. 89, 92, ¶ 9, 970 P.2d 443, 446 (App. 1998) (quoting *W.J. Kroeger Co. v. Travelers Indem. Co.*, 112 Ariz. 285, 288, 541 P.2d 385, 388 (1975)). As the party alleging the right of recoupment, the

County had the burden of proving the applicability of the doctrine by a preponderance of the evidence. *In re Nat'l Audit Def. Network*, 332 B.R. 896, 913 (Bankr. D. Nev. 2005) (citation and internal quotation omitted).

¶47 As an initial matter, we reject the Hospitals' argument that the County's recoupment claims are barred because of the voluntary nature of the County's payments. Generally, "[p]ayment of money resulting from a mistake by the payor as to the existence or extent of the payor's obligation to an intended recipient gives the payor a claim in restitution against the recipient to the extent the payment was not due." Restatement (Third) of Restitution & Unjust Enrichment § 6(2) (Tentative Draft No. 1, 2001).

¶48 Restitution is barred, however, when there is no doubt of the indebtedness, the payment is made "without mistake, in the absence of fraud, duress and coercion and when the payment should have been made in equity and good conscience." *Tway v. S. Methodist Hosp. & Sanitorium*, 48 Ariz. 490, 495-96, 62 P.2d 1318, 1320 (1936) (internal quotation omitted). "[M]oney voluntarily paid in the face of a recognized uncertainty as to the existence or extent of the payor's obligation to the recipient may not be recovered, on the ground of 'mistake,' merely because the payment is subsequently revealed to have exceeded the true amount of the underlying obligation."

Restatement (Third) of Restitution & Unjust Enrichment § 6 cmt. e (Tentative Draft No. 1, 2001) (emphasis omitted). In this case, the County contends it mistakenly paid the Hospitals' claims, and it is undisputed that the County's payments were not made in settlement of the claims or in compromise of uncertain liability.

¶49 To prevail, however, the County was required to show the amounts of any payments it sought to recoup and to demonstrate that it made the payments in error. The Special Master found in each trial that the County's recoupment claims were not supported by credible evidence. Generally, we review findings of fact in a light most favorable to upholding them, "and we must not set them aside unless they are unsupported by any credible evidence." *Packer v. Donaldson*, 16 Ariz. App. 294, 300, 492 P.2d 1232, 1238 (1972). However, the Special Master preceded each of his findings on recoupment with a statement that he was relying on his conclusions as to the credibility of the witnesses in making his determinations. Witness credibility, however, cannot be a guiding consideration on the County's recoupment claims unless the witnesses at issue had first-hand knowledge of evidence bearing on recoupment. We cannot discern from the record whether any witness with first-hand knowledge testified as to this issue. Therefore, we remand for a factual determination based on the evidence as to the

amounts of any payments made by the County to the Hospitals in error that qualify for recoupment.

2. Slow-Pay penalties.

¶50 The trial court adopted the Special Master's assessment of slow-pay penalties against the County in the Post-Claims Resolution trial pursuant to A.R.S. § 11-297.01(C)(5) (1999) (repealed 2001), which provided that if the County failed to timely pay a claim, it would be responsible for penalties calculated from its receipt of the claim.[15] The County argues the penalties are improper because the Hospitals did not attempt to establish that they fulfilled the statutory requirements for filing the claims.

¶51 Former section 11-297.01(C)(5) provided that if the County failed to timely pay a claim, it would be liable for penalties calculated based on the period of delay from its receipt of the claim.[16] For purposes of A.R.S. § 11-297.01(D), a claim was considered received "on receipt of the legible, error-free claim by the county," and an "error-free claim" was further

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[15] The trial court also awarded slow-pay penalties against the County in the Claims Resolution trial. The County does not challenge that ruling on appeal and we do not consider it.

[16] The statute stated that if a county paid a hospital's bill more than sixty days after the date it received the bill, the county would pay one hundred percent of the charges allowed by statute plus "a fee of one per cent for each thirty day period or portion of each thirty day period following the sixtieth day of receipt of the bill until the date of payment." Former A.R.S. § 11-297.01(C)(5).

defined by A.R.S. § 11-290(2) (1999) (repealed 2001) as one that could be "processed without obtaining additional information from the provider or third party." Claims for medical care were required to include an admission fact sheet or registration record, an itemized statement, an admission history and physical, and, if applicable, a discharge summary, an emergency record, operative reports, and a labor and delivery room report. Former A.R.S. § 11-297.02(B).

¶52 The Hospitals contend the County is precluded from raising this issue because it did not appeal a prior ruling by the Special Master in the Claims Resolution phase and thus, the County waived the statutory submission requirements set forth in former A.R.S. § 11-297.02(B). The County responds that although the prior ruling may have precluded it from arguing that a claim was not payable because it did not contain the required documentation, that ruling did not foreclose it from arguing that the Hospitals did not establish "receipt" for purposes of imposition of slow-pay penalties. We disagree.

¶53 The Special Master ruled in the Claims Resolution phase that, when read in conjunction, the statutes did not require the Hospitals to submit each of the items enumerated in A.R.S. § 11-297.02(B), but only required them to submit the documentation required to process a given claim. He also found, as a matter of fact, that the County waived any such submission

requirements through its course of conduct. The Special Master did not limit his determination regarding the meaning of "receipt" to the context of whether a claim was payable. Accordingly, the County is precluded from arguing that the Special Master's award of slow-pay penalties fails as a matter of law because the Hospitals did not offer proof that the County received each of the claims. *Corbett*, 213 Ariz. at 624, ¶ 16, 146 P.3d at 1033 (citation omitted) ("Under collateral estoppel, once an issue is actually and necessarily determined by a court of competent jurisdiction, that determination is conclusive in subsequent suits.").

¶54 Moreover, even if the County was not bound by the Special Master's earlier ruling, the statutory analysis would not differ for the purpose of imposing slow-pay penalties. Slow-pay penalties were imposed based upon the date the claim was received under former A.R.S. § 11-297.01(C)(5). A claim was "considered received on receipt of a legible, error-free claim" that contained certain enumerated documents. Former A.R.S. § 11-297.01(D). An "error-free claim" was defined as one that could be processed without obtaining additional information from a hospital or third party. Former A.R.S. § 11-290(2). Thus, the Hospitals were not required to submit each of the enumerated documents as a precondition to payment, but only those documents necessary to allow the County to process the claim.

Accordingly, evidence that the County did, in fact, process a given claim is sufficient to support a finding that the County received the claim and may be used to determine the date from which slow-pay penalties may be assessed. Any other reading of the statute would sanction the County's fiction that it never received claims that it processed and for which it engaged in the statutorily mandated claims resolution dispute process. *See Lake Havasu City v. Mohave County*, 138 Ariz. 552, 557, 675 P.2d 1371, 1376 (App. 1983) ("Statutes must be given a sensible construction which will avoid absurd results.").

3. Fragmented charges.

¶55 The County also challenges the court's partial summary judgment for the Hospitals on the County's fragmented charges defense.

¶56 Arizona counties were responsible for "all costs" incurred by private hospitals providing emergency care to indigent patients. Former A.R.S. § 11-297.01(B). In 1984, however, the legislature allowed the counties to reimburse hospitals for emergency indigent care at the same discounted rate prescribed by the AHCCCS statutes. *Id.* The AHCCCS scheme relies upon "adjusted billed charges" in order to maintain hospital reimbursement at 1984 levels. *Carondelet Health Servs., Inc. v. AHCCCS Admin.*, 182 Ariz. 221, 224, 895 P.2d 133, 136 (App. 1994); *see* A.R.S. § 36-2903.01(G) (2009). Under this

process, each hospital is required to file with the Arizona Department of Health Services a "schedule of rates and charges" that contains "a listing of all services performed and commodities furnished for which a separate charge is made, together with the charges for each." A.R.S. § 36-436.01(A) (2003). The agency then assigns each hospital a multiplier (the ABC factor) that is used to convert its "full billed charges" into "adjusted billed charges." *Carondelet*, 182 Ariz. at 224, 895 P.2d at 136. "When a hospital submits a bill for an [indigent] patient, the full billed charges are multiplied by that hospital's ABC factor in order to discount the charges to the level reflected in the hospital's 1984 schedule of rates and charges." *Id.* The County denied portions of the Hospitals' claims because, it alleged, the Hospitals improperly "fragmented" their charges by billing separately for items and services that were customarily billed together in 1984 in an attempt to avoid the statutory limit on reimbursement rates.

¶57 Before the Cycles trial, the Hospitals moved for partial summary judgment on the County's "fragmented charges" defense. The Hospitals argued they had the exclusive right to set their own rate structure and the County could not refuse to pay "all costs" of treating indigent County residents by claiming the costs should be included in other charges. The County opposed the motion, asserting that its refusal to pay

"fragmented charges" was simply an attempt to avoid paying more than the customary charges imposed for non-indigent care and that a question of fact regarding what charges were customary precluded summary judgment. The Special Master ruled the County was required to pay all costs the Hospitals incurred providing emergency care to indigent patients subject to the statutory discount rate, found that no genuine issue of material fact existed and recommended that the court grant the motion. Over the County's objection, the court accepted the Special Master's recommendation and granted partial summary judgment for the Hospitals on this issue.

¶58 The County argues on appeal that the court's ruling was erroneous because a question of fact existed regarding the Hospitals' billing practices. Arizona law required the County to pay "all costs" the Hospitals incurred in providing emergency care to indigent County residents, subject to the adjusted billed charges discount. A.R.S. § 11-297.01(B). The statute did not limit county liability to "customary" charges or to any billing method, but required a county to pay "all costs" incurred by the hospital. Former A.R.S. § 11-297.01(B). We therefore reject the County's argument that it was not required to pay for supplies or services customarily included in other charges.

¶59 We agree that the Hospitals cannot, consistent with the statute, use novel billing techniques to inflate their entitlement to reimbursement beyond the actual costs allowed. But the County did not offer sufficient evidence regarding the scope of customary charges to create a material question of fact on this issue. The County submitted the affidavit of Cheryl Wilson, the supervisor of medical review for the County's Department of Health Care Mandates, who averred that the County disallowed "fragmented charges." She opined, for example, that a hospital charge for "OR Time 1/2 Hr 2 Staff" would customarily include routine surgical supplies and a charge for "OR Anesthesia 1/2 HR" would customarily include routine supplies and asserted it was appropriate for the County to refuse to pay other charges for the same supplies. Wilson did not explain the basis for her conclusion that the supplies customarily would be included in other charges, however, and did not offer any evidence that other charges for equipment or services submitted by the Hospitals customarily would be included in other charges.

¶60 The trial court properly granted summary judgment for the Hospitals on this issue.

4. Statute of limitations.

¶61 The County contends the Special Master improperly granted seven[17] of the Hospitals' claims that were barred by A.R.S. § 11-630 (2001), which required the Hospitals to file suit within six months after the County Board of Supervisors ratified the denial of the claims.[18]

¶62 The Hospitals assert the County did not raise this argument in the trial court except as to Donna M. and therefore waived the argument as to all other claims. As the record reveals the County did assert in the court below that these claims were time-barred under A.R.S. § 11-630, we therefore find no waiver. Except for the claim for services provided to Donna

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[17] The relevant claims were for treatment of Kristin Y. (Desert Samaritan), Judith B. (Good Samaritan), Margaret F. (Maryvale), Lance I. (Mesa Lutheran), Suzanne D. (Phoenix Regional), Marciel F. (St. Joseph's), and Donna M. (St. Joseph's). The County withdrew its statute of limitations argument regarding Viola R. (Emergency Professional).

[18] The County argues for the first time in its reply brief that these claims also were barred by A.R.S. § 11-622(C) (2001), which required the Hospitals to submit their claims to the County Board of Supervisors within six months of the ending date of service. The Hospitals moved to strike this argument as untimely. We do not consider arguments raised for the first time in a reply brief. ARCAP 13.c; *United Bank v. Mesa N. O. Nelson Co.*, 121 Ariz. 438, 443, 590 P.2d 1384, 1389 (1979). We therefore grant the Hospitals' motion and will not consider this argument. Further, although the County stated in its briefs in the Claims Resolution and Post-Claims Resolution appeals that it adopted its statute of limitation arguments from the Cycles phase, it did not identify any specific claims litigated in those cases to which limitations might apply. We therefore do not consider the limitations issue in the Claims Resolution and Post-Claims Resolution appeals.

M., however, the only evidence the County cites is the date the Hospitals submitted the claim to the County Board of Supervisors and does not establish that the Hospitals failed to file suit within six months after the Board denied the claims. Thus, the Special Master's findings that these claims were not barred by the statute of limitations were not clearly erroneous.

¶63 As to the claim for services to Donna M., the County submitted evidence in the trial court that the Board of Supervisors ratified the denial of the claim on September 10, 1997, and it is undisputed that the Hospitals filed the lawsuit, including this claim, on May 15, 1998. The Hospitals do not cite, and we do not find, any evidence that would support their contention that a factual dispute existed regarding whether this claim was barred by A.R.S. § 11-630. Accordingly, the Special Master's determination that this claim was not time-barred was clearly erroneous.

D. Prejudgment Interest.

1. Liquidated damages.

¶64 "Entitlement to an award of prejudgment interest is a matter of law [we] review[] de novo." *John C. Lincoln*, 208 Ariz. at 544, ¶ 39, 96 P.3d at 542. When prejudgment interest is available, it is awarded as a matter of right, rather than discretion, when a claim is liquidated. *Paul R. Peterson Const., Inc. v. Arizona State Carpenters Health & Welfare Trust*

Fund, 179 Ariz. 474, 484, 880 P.2d 694, 704 (App. 1994). A claim is liquidated when the precise amount owed can be calculated "with exactness, without reliance upon opinion or discretion." *John C. Lincoln*, 208 Ariz. at 544, ¶ 39, 96 P.3d at 542.

¶65 The County argues that the amounts of the claims in these cases cannot be computed with exactness because of the "doctor-bill spend-down assumption," by which medical expenses incurred by the patient before hospital admission are treated as a fixed percentage of hospital charges for purposes of determining the patient's income in assessing indigency. The County notes that the calculation of reimbursement due on each of the claims depends upon application of this spend-down assumption, "which this court approved in *John C. Lincoln*, long after these claims were processed." However, this Court in *John C. Lincoln* also held that such claims nevertheless were liquidated and subject to an award of prejudgment interest as a matter of right. *Id.* at 545, ¶ 44, 96 P.3d at 543. This Court noted:

> [E]ach hospital was assigned an 'adjusted billing charge' discount factor . . . which, when multiplied by the applicable filed rate charges, produces a precise reimbursement amount that the hospital is due for each submitted claim. . . . The amount of the claims in this case were capable of exact calculation. (sic) The Hospitals provided a specific method of calculation and the requisite data to enable the County to ascertain the exact amount owed.

Id. at 545, ¶¶ 42, 44, 96 P.3d at 543. Likewise, in these cases, formulas were known and available by which the exact amount owed on the claims could be calculated without relying on opinion or discretion.

¶66 The County argues that this case differs from *John C. Lincoln* in that the Special Master reduced the doctor-bill assumption from 25% to 15% for claims on and after May 1, 2000, making it "impossible to calculate the amount of [those] claims" when they were submitted. The Hospitals argue in response that the liquidated status of a claim turns on the nature of the claim when made, not on the eventual outcome of the lawsuit.

¶67 In *Trus Joist Corp. v. Safeco Ins. Co. of Am.*, 153 Ariz. 95, 109, 735 P.2d 125, 139 (App. 1986), this Court held that "[a] claim is not considered unliquidated merely because the jury must find certain facts in favor of the plaintiff in order to determine the amount of damages." In that case, this Court upheld an award of prejudgment interest against the defendant beginning on the date the defendant offered to settle the claim for a specific amount. *Id.* at 110, 735 P.2d at 140. The defendant had offered to settle the claim for $195,000, but the main plaintiff rejected that offer. *Id.* at 98, 735 P.2d at 128. The plaintiffs produced evidence that a reasonable amount to settle the claim exceeded $250,000. *Id.* at 109, 735 P.2d at

139. After trial, a jury returned a verdict against the defendant for $267,434 in compensatory damages and $10,000,000 in punitive damages. *Id.* at 98, 735 P.2d at 129. The trial court later vacated that award, finding it to be "clearly excessive," and entered judgment for plaintiffs for $250,000 plus prejudgment interest. *Id.* at 98, 102, 735 P.2d at 128, 132. In affirming the award of prejudgment interest from the date the settlement offer was made, this Court stated that "mere differences of opinion as to the amount due under a contract does not preclude an award of prejudgment interest." *Id.* at 109, 735 P.2d at 139 (citing *Homes & Son Const. Co., Inc. v. Bolo Corp.*, 22 Ariz. App. 303, 306, 526 P.2d 1258, 1261 (1974)). "All that is necessary is that the evidence furnish data which, if believed, makes it possible to compute the amount with exactness." *Id.*

¶68 Likewise, in this case, the Hospitals' claims, when submitted to the County, contained data which, if accepted, made it possible for the County to compute exactly the amount it owed each Hospital. The liquidated status of the claims when submitted is not changed by the Special Master's later decision to adjust the doctor-bill assumption percentage, any more than the liquidated status of the claim in *Trus Joist* was affected by

the eventual award of damages by the trial court in that case.[19] The claims here were liquidated, and prejudgment interest is owed as a matter of right on those claims deemed on remand to be valid.

2. Sufficient information received.

¶69 Under former A.R.S. § 11-291(G),[20] a hospital bill for indigent care was considered "received" by the County

> "if the claim includes the following error-free documentation in legible form: 1. An admission face sheet. 2. An itemized statement. 3. An admission history and physical. 4. A discharge summary or an interim summary if the claim is split. 5. An emergency record, if an admission was through the emergency room. 6. Operative reports, if applicable. 7. A labor and delivery room report, if applicable."

¶70 The County argues that claims the Hospitals submitted from 1996 through September 1999 were never "received" by the County, as defined under the former statute, and therefore no prejudgment interest should be awarded. The County cites *Homes* for the rule that prejudgment interest does not begin to run until the creditor supplies the debtor with "sufficient information and supporting data so as to enable the debtor to ascertain the amount owed." 22 Ariz. App. at 306, 526 P.2d at

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[19] This conclusion is bolstered by our holding at *supra* ¶¶ 23-25 that the County is collaterally estopped from arguing that no doctor-bill spend-down assumption may be applied in calculating patient income.

[20] The subsequent amendments to this statute do not affect our decision on this issue.

1261. The County argues that the requirements for receipt under former A.R.S. § 11-291(G) provided for such "sufficient information," and that because those requirements were not met, prejudgment interest should not have accrued. The Hospitals counter that the definition of "received" in former A.R.S. § 11-291(G) did not govern the calculation of prejudgment interest.

¶71 In Arizona, allowable prejudgment interest generally accrues from the date of an initial demand for payment. *Alta Vista Plaza Ltd. v. Insulation Specialists Co.*, 186 Ariz. 81, 83, 919 P.2d 176, 178 (App. 1995). The demand, however, must itemize the damages. *Id.* So long as the demand or notice provides the debtor with enough information to determine the amount owed, it is sufficient. *Id.* at 84, 919 P.2d at 179. There was never a requirement in former A.R.S. § 11-291(G) that the demand comply with the definition of "received" to constitute "sufficient information." Here, the Special Master found, based on information supplied by the parties, that the Hospitals provided the County with sufficiently itemized demands for payment as of the dates the Hospitals submitted their claims. Accordingly, the court properly awarded the Hospitals prejudgment interest.

3. Hospitals' appeal from Claims Resolution judgment: Timeframe of prejudgment interest.

¶72 The Hospitals argue, with respect to claims in the Claims Resolution phase that were the subject of a settlement agreement in June 2004, that the trial court erred when it failed to award any prejudgment interest for the time period prior to the effective date of the settlement. The trial court concluded that former A.R.S. § 11-297.03 precluded an award of prejudgment interest for the time period prior to the settlement and "needs no interpretation or construction." That statute stated that "[d]uring the claims resolution process, a claim is not subject to a payment penalty . . . and interest shall not accrue." Former A.R.S. § 11-297.03(F). The trial court's decision was based on that statute and on language in the June 2004 settlement agreement, which stated, "[t]he parties will submit a stipulation and proposed order to the court providing that the claims resolution process is over on the Effective Date. The Effective Date shall be seven (7) calendar days after the Board of Supervisors' approval of this settlement agreement."

¶73 The Hospitals argue that the statute only allowed for interest to be tolled during the claims resolution process for a maximum of 225 days. Alternatively, the Hospitals argue this Court must engage in statutory interpretation in applying the

statute to these claims and thereby arrive at a different conclusion, either because the statute is ambiguous or to avoid an absurd result.

¶74 Under the statute, once a hospital disputed the County's denial of a claim and requested claim resolution, the parties had up to 180 days to make relevant documents available to each other and "attempt to resolve the dispute."[21] After the period for document exchange was over, the County generally had forty-five additional days to provide the hospital with written notice of its decision.[22] Therefore, the Hospitals argue that the claims resolution process during which prejudgment interest should not have accrued lasted at most for 225 days.

¶75 If the language of a statute is clear and unambiguous, we need look no further than the language itself, and we will follow it as written without resorting to other methods of statutory interpretation. *Bentley v. Building Our Future*, 217 Ariz. 265, 270, ¶¶ 12-13, 172 P.3d 860, 865 (App. 2007) (citation and internal quotation omitted). A statute is ambiguous if "there is more than one rational or reasonable interpretation of the statute." *Id.* at 270, ¶ 13, 172 P.3d at 865 (citation omitted). When a statute is ambiguous or unclear, the court may resort to the rules of statutory interpretation to

[21] Former A.R.S. § 11-297.03(B) and (C).

[22] Former A.R.S. § 11-297.03(D).

determine legislative intent. *Id.* When engaging in statutory interpretation, we consider the statute's context, subject matter, historical background, effects and consequences and its spirit and purpose. *Id.* "When interpreting a statute, 'we must read the statute as a whole and give meaningful operation to each of its provisions.'" *Higginbottom v. State*, 203 Ariz. 139, 142, ¶ 13, 51 P.3d 972, 975 (App. 2002) (quoting *Ruiz v. Hull,* 191 Ariz. 441, 450, ¶ 35, 957 P.2d 984, 993 (1998)).

¶76 The Hospitals urge that viewing former A.R.S. § 11-297.03 as a whole, the phrase "during the claim resolution process" meant during the period beginning when the County received a hospital's dispute letter and ending, at most, 225 days later. According to the trial court, however, when, as here, there is a written agreement stipulating when the claim resolution process ends, the claim resolution process lasts until that date.

¶77 A contract "is always to be construed in the light of the statute, of the law then in force." *Higginbottom*, 203 Ariz. at 142, ¶ 11, 51 P.3d at 975 (internal quotations omitted). "[W]here a contract is incompatible with a statute, the statute governs." *Id.* However, where any inconsistency can be avoided by giving meaningful operation to both the contract and the statute, this Court will choose to reconcile the two. *Id.* at 143, ¶ 14, 51 P.3d at 976.

¶78 The statute stated that the claims resolution process "ends when the county provides notice pursuant to subsection D, E or H of this section." Former A.R.S. § 11-297.03(F). As explained above, subsection D pertained to notice by the County of a final decision within forty-five days after the end of the document-exchange period. Former A.R.S. § 11-297.03(D). Subsection E applied to situations in which all the relevant documents had been made available and the parties subsequently agreed in writing that the dispute could not be resolved through the claims resolution process. Former A.R.S. § 11-297.03(E). Former section 11-297.03(E) called for the County to issue a written notice within forty-five days after the parties made this agreement. *Id.* However, it contained no time frame in which the parties needed to reach such an agreement after the documents were disclosed. Subsection H applied to situations in which the Board of Supervisors and a hospital established an alternative claims resolution process with a resolution completion date. Former A.R.S. § 11-297.03(H). This subsection likewise did not contain a specific time frame within which the alternative process must be completed, only that there must be a resolution date established. *Id.*

¶79 Under the terms of the June 2004 settlement agreement, the parties agreed to the dismissal of certain claims and counterclaims related to the claims resolution process, the

filing of a new complaint and an end to the claims resolution process. The settlement agreement therefore constituted an agreement by the parties "in writing that the dispute cannot be resolved through the claims resolution process." If, as the County implies, the process never reached a point at which all relevant documents were exchanged, this agreement would not strictly fall under A.R.S. § 11-297.03(E). However, the situation here is more akin to the situation envisioned in A.R.S. § 11-297.03(E) than in A.R.S. § 11-297.03(D), because subsection D applied when the claims resolution process resulted in a resolution. Because subsection E contained no deadline for reaching a mutual conclusion that claims resolution would not work, enforcing the date specified in the settlement agreement establishing the end of the claims resolution process is not inconsistent with the statutory scheme.

¶80 The Hospitals argue that the statute is ambiguous because it does not contemplate a situation such as exists in this case. *See Lowing v. Allstate Ins. Co.*, 176 Ariz. 101, 104, 859 P.2d 724, 727 (1993) (reasoning that because a statute's literal language did not contemplate a particular situation it was ambiguous). The Hospitals argue that the statute "contemplated only success," not a claims resolution process that "became a fiasco" and "dragged out for four years." We disagree. At subsection E, the statute contemplated a situation

in which a dispute could not be resolved through the claims resolution process, and it did not establish a time limit for coming to such a conclusion. Therefore, we find no ambiguity.

¶81 Finally, the Hospitals argue that applying the statute to toll prejudgment interest until the conclusion of the claims resolution process in this case produces an absurd result at odds with legislative intent. *See State v. Estrada*, 201 Ariz. 247, 251, ¶ 17, 34 P.3d 356, 360 (2001). ("A result is absurd if it is so irrational, unnatural, or inconvenient that it cannot be supposed to have been within the intention of persons with ordinary intelligence and discretion." (internal quotations omitted)). Additionally, this Court will not apply the plain language of a statute if doing so would lead to a result at odds with the legislature's intent. *Id.* at 251, ¶ 19, 34 P.3d at 360.

¶82 The Hospitals argue that the "aim" of A.R.S. § 11-297.03 was to resolve claims on an expedited basis. They point to the law's requirement at subsection A that the County and the Hospitals put forth "a good faith effort to resolve the disputed claim through the claims resolution process."[23] Additionally, they point to the purpose of the law requiring prejudgment

[23] The Special Master found that "[w]hile the evidence as to relative blame is in conflict . . . [the] County was responsible for extreme delays in the claims resolution process and failed to participate in that process in good faith."

interest on certain liquidated claims, A.R.S. § 44-1201(A) (2003), "not only to recompense the victim but to deter defendants from attempting to benefit from delays in litigation." *Trimble v. Am. Sav. Life Ins. Co.*, 152 Ariz. 548, 557-58, 733 P.2d 1131, 1140-41 (App. 1986). The Hospitals assert that because of the actions of the County, "[c]laims resolution . . . became a travesty of what the legislature intended." Therefore, they contend, tolling prejudgment interest until the agreed-upon end of the claim resolution process wrongfully rewards the County for thwarting the intent of the legislature and acting in bad faith.

¶83 The County argues that during the claims resolution process, the Hospitals' attorneys "did not press for adherence to the statutory timetable" until the County engaged in a more aggressive review of the Hospitals' claims. "At odd, lengthy intervals [the Hospitals' attorneys] wrote an occasional self-serving letter to the County complaining that the County was not living by the deadlines. . . The plaintiffs' actions, however, were inconsistent with their rhetoric." The County asserts that the Hospitals also ignored deadlines for document production and were also to blame for the breakdown in the claims resolution process. It states that the Hospitals "abused the process" and that "[b]oth sides simply lumbered on until [the Hospitals] decided to abort the process." The County additionally points

out that if the Hospitals wanted to end the claims resolution process sooner, so as to trigger the accrual of prejudgment interest under the statute, they could have asked the County before June 2004 to agree with them that the claims resolution process had failed, but did not do so.

¶84 "[T]he legislature enacted [A.R.S. § 11-297.03(F)] to halt accruing prejudgment interest during the claims resolution process . . . ." *John C. Lincoln*, 208 Ariz. at 545 n.10, ¶ 42, 96 P.3d at 543 n.10. Section 11-297.03(F) thus created an exception to the rule requiring accrual of prejudgment interest on liquidated claims while the claims resolution process was ongoing.

¶85 There was evidence that the Hospitals played a role in continuing the claims resolution process and that they failed to request that the County agree with them before June 2004 that the process would not work. This allowed the process, and the related tolling of prejudgment interest, to continue. Given that, we do not find it absurd or contrary to the legislature's intent to enforce the plain language of the statute against the Hospitals. We therefore affirm the court's ruling that pre-judgment interest on claims in the Claims Resolution phase accrued from June 23, 2004.

CONCLUSION

¶86 In the Opinion issued this date, we reverse and remand these cases to the trial court for the reasons stated therein. On remand, the court shall conduct further proceedings consistent with the Opinion and the legal rules and conclusions outlined in this memorandum decision.

/s/
_____
PATRICIA A. OROZCO, Presiding Judge

/s/
_____
DIANE M. JOHNSEN, Judge

/s/
_____
PETER B. SWANN, Judge