State of Arizona

COMMISSION ON JUDICIAL CONDUCT

Disposition of Complaint 20-339

Judge:

Complainant:

ORDER

February 24, 2021

The Complainant alleged a superior court judge acted without subject matter jurisdiction and made rulings in violation of established law.

The role of the Commission on Judicial Conduct is to impartially determine whether a judicial officer has engaged in conduct that violates the Arizona Code of Judicial Conduct or Article 6.1 of the Arizona Constitution. There must be clear and convincing evidence of such a violation in order for the Commission to take disciplinary action against a judicial officer.

The Commission does not have jurisdiction to overturn, amend, or remand a judicial officer's legal rulings. The Commission reviewed all relevant available information and concluded there was not clear and convincing evidence of ethical misconduct in this matter. The complaint is therefore dismissed pursuant to Commission Rules 16(a) and 23(a).

Commission member Denise K. Aguilar did not participate in the consideration of this matter.

Copies of this order were distributed to all
appropriate persons on February 24, 2021.

CONFIDENTIAL
Arizona Commission on Judicial Conduct
1501 W. Washington Street, Suite 229
Phoenix, Arizona 85007

FOR OFFICE USE ONLY

20-339

COMPLAINT AGAINST A JUDGE

Name: _____ **Judge's Name:** _____

Instructions: Use this form or plain paper of the same size to file a complaint. Describe in your own words what you believe the judge did that constitutes judicial misconduct. Be specific and list all of the names, dates, times, and places that will help the commission understand your concerns. Additional pages may be attached along with copies (not originals) of relevant court documents. Please complete one side of the paper only, and keep a copy of the complaint for your records.

The short is the Judge has made up facts, and laws. IE. The medical provider claimed a medical lien to gain assignment rights in the proceeds of a personal injury claim, then under oath, the provider and their billing department swore they did not have a medical lien; however the judge found in his rulings that the provider did have a medical lien. It is strange because the provider uses unperfected medical liens to balance bill through PI assignments habitually, this was demonstrated at the trial, yet the judge opted to forgo that information and the testimony of the parties claiming no medical lien to justify the judgment he passed. Not to mention the judge is overruling several supreme courts and appeals court rulings in regards to perfected medical liens and assignments in personal injury.

It is hard to defend myself when the judge is making up his own rule book that contradicts all the laws, and case law. In the same regard to the provider, he was an with my self-funded plan. The plan that the provider and I have contracted with each other through has explicit written instructions on non-liability for administratively denied claims, and further explicit instructions on required written contracts if the provider is attempting to provide out of network services. These were clearly addressed at trial, yet the Judge has opted to invalidate the written contracts because of an alleged oral contract. Once again I have no idea how to defend myself from fictional oral allegations outside of showing the clearly written contract prevents any such arrangement. I presume my plan has this to prevent such an issue from ever taking place. The two issues this brings up are 1: Why is he making determinations of an plan when this falls under federal jurisdiction? He is essentially deciding (setting a bad precedent) for what quantifies an contract in some odd states with this ruling. 2: Why is he allowing an alleged oral contract to supersede a written contract in defiance of Arizona case-law?

The second half of the same interpleader trial involved a lawyer I terminated in Would have been sooner but I had to consult an attorney because due to the wording of his contract I did not believe I could fire him (contingent on ANY OFFER to settle). Well, a after I fired the attorney he mentions he has an offer to settle on his desk from the day I fired him, he just didn't open it until after I fired him. He was asserting a full contingency and lien based on the offer to settle despite my rejecting it. Meanwhile, I am continuing to talk with the Insurance rep, but also seeking out additional treatment because my hip was still hurting. Long story short I had to get surgery on my hip, didn't know if my health plan would cover or assert subrogation rights, so I filed a law-suit I end up needing an attorney so I reach out to asking how much I needed to pay him so I could hire another attorney. He was still asserting a contractual lien based on the offer to settle. This is years later.

So the back story is to point out the fatal flaw in his contract. IE contingency on any OFFER to settle. ER contingency is on an outcome there are only allowed settlement, judgment, and appeal (the specific language of ER ; the best way I have heard this explained is that if an offer to settle is a contingency it removes the client's rights under on if they wish to accept the offer to settle or not. The other issue is that because the matter is not concluded if the attorney is asserting an equitable lien on the proceeds of the clients claim and this would typically be a violation of 1.8, but in Arizona an assignment in personal injury is illegal, so it is an illegal and unethical assignment.

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I have spelled the issues with the attorney liens out very clearly for the judge, I have also done so for the bar and they have told the attorney to stop using his contract because it violates ER1.5. I do think the bar refused to address the assignment issue trying to play off like a lien is a matter of law; however clearly a lien is an assignment and in as far as the contract did not have the proper language on er 1.8 it was an ethical violation, and perhaps if that were addressed by the bar the remaining illegal assignment in PI would be a matter of law...

But instead of the judge preventing this he has rewarded the attorney and punished me in the form of attorney fees for daring to dispute the issue. $ in attorney fees to collect under $ .. The final issue is that this would be easy to address on appeals, but the judge has thrown so many attorney fees at me there is no possibility of myself being able to afford to stave off judgment while proceeding with the claim. The really messed up part is that the largest attorney fees violate the rules of civil procedure.

Arizona Rules of Civil Procedure 54(g)4: Unless a statute or court order provides otherwise, a motion for attorney's fees must be supported by affidavit and is governed by Rule 7.1. The movant's affidavit must disclose the terms of any fee agreement for the services for which the claim is made.

was awarded attorney fees without a fee agreement or terms of the fee agreement. alleged to have charged over $ in attorney fees to collect under $ in chiropractic bills that would have been under $ had he gone through my contract. The fact that Judge not only awarded attorney fees without a fee agreement but actually believed time chart that alleged $ in fees say enough about his judgment...

This case has been tainted fruit from the beginning, and only by making a ruling in a vacuum that ignored all other items besides the ones that would make the judge's ruling correct could he have ever come to the conclusions he did. At the base these are claims of assignment in the funds of personal injury, they fail there, then they are a breach of the contract, they fail there, while Silence's contract is explicitly unethical, they fail there. Not to mention any contract that claims to give a person an assignment in another person's personal injury claim are void as against public policy per the Arizona Court of Appeals.

I wanted a bench trial because I wanted the laws applied as they should be and to be done with it, instead Judge has opted to create the facts that would support his judgment and ignored all laws, and facts that were contrary to it, even when those facts are hard in-writing facts vs oral alligations.

Other issues at trial. The other two parties messed up on numbering their exhibits, so all of mine would be off, which cost me of my trial time (the time I needed for my testimony) over the CVOID video trial, I requested the time back because of their error, the judge has refused. The judge issued a ruling without review my pretrial statement and legal memorandum yet came to the same ruling, and just adjusted facts to make it work. Last he made the finding of facts and conclusions of law a after the ruling despite the request before trial.

I think there are really three options; 1: Judge is new and prone to mistakes. 2: He used to be a personal injury attorney and is biased. 3: His illness has gotten the better of him and he needs a different career path. I am leaning towards 3 because his review of the matter and constant mistakes make it appear that he was just kind of tuned out and it was too much effort to review the facts. I am hopeful the system isn't so broken and he will surprise me, but the fact I have written this shows how little hope I have in that.

CONTINGENT
FEE AGREEMENT

CLIENT: _____ **DATE :** _____

* Client retains (Hereinafter Attorney) and such associate counsel as attorney may deem advisable, to represent Client for personal injuries and property damage arising out of a motor vehicle accident which occurred on _____.

- Client agrees to pay Attorney for all professional legal services as follows:

  A. 30% of any settlement offers or gross recovery made on client's personal injury claim if settled prior to the filing of a lawsuit. Said fee to increase to 33% should litigation be initiated.

  B. Attorney may advance costs, if any. Said costs to be recoverable by Attorney after deduction of attorney fees.

- Client understands that the attorney fees herein are not set by law, but are the result of a contractual agreement between the Attorney and Client.

- Client consents to receiving communications via email. Client consents to electronic cloud based data storage of their file contents.

IF THERE IS NO RECOVERY THERE ARE NO ATTORNEYS FEES

Date: _____ _____

Client: _____

Compensation

Charging Customers

Additional fees for covered services

You may not charge our Customers fees for covered services beyond copayments, coinsurance or deductibles as described in their benefit plans. You may not charge our Customers retainer, membership, or administrative fees, voluntary or otherwise. This includes, but is not limited to, concierge/boutique practice fees, as well as fees to cover increases in malpractice insurance and office overhead, any taxes, or fees for services you provide that are denied or otherwise not paid due to your failure to notify us, to file a timely claim, to submit a complete claim, to respond to our request for information, or otherwise comply with our protocols as required by your agreement with us, or based on our reimbursement policies and methodologies. This does not prevent you from charging our Commercial Customers nominal fees for missed appointments or completion of camp/school forms. Please note, however, that for Medicare Advantage Customers, does not allow the Provider to charge for "missed appointments" unless the Provider has previously disclosed that policy to the Customer.

Charging Customers for non-covered services

You may seek and collect payment from our Customers for services not covered under the applicable benefit plan, provided you first obtain the Customer's written consent. For Commercial Customers, the consent must be signed and dated by the Customer prior to rendering the specific service(s) in question. Retain a copy of this consent in the Customer's medical record. In those instances in which you know or have reason to know that the service may not be covered (as described below), the written consent also must include: (a) an estimate of the charges for that service; (b) a statement of reason for your belief that the service may not be covered; and (c) in the case of a determination by us that planned services are not covered services, a statement that UnitedHealthcare has determined that the service is not covered and that the Customer, with knowledge of determination, agrees to be responsible for those charges.

For , in addition to first obtaining the Customer's written consent as indicated above, the following must also occur in order for you to seek and collect payment from our Customer for a non-covered service or item.

- If you know or have reason to know that a service or item you are providing or referring may not be covered (as described below), you must request a pre-service organization determination from prior to providing or referring for the service or item and must issue a determination before you render or refer for the non-covered service or item.
- If after you request a pre-service determination, determines that the service or item is not covered, will issue an Integrated Denial Notice (IDN) to the Customer and you. The IDN informs the Customer of his or her liability for the non-covered service or item and appeal rights. You must make sure the Customer has received the IDN prior to rendering or referring for non-covered services or items in order to collect payment. Please be aware that when a Customer wishes to receive a non-covered service or item, requires that the Customer be provided an IDN in order for the Customer to be financially liable for the non-covered service or item unless the service or item is clearly excluded in the EOC or other related materials.
- A pre-service organization determination is not required in order to seek and collect payment from the Customer where the Member's Evidence of Coverage (EOC) or other related materials is clear that a service or item is never covered.

A pre-service organization determination must be requested by submitting an Advance Notification request in the Eligibility and Benefits Center on Link or using → Notifications/Prior Authorizations → Notifications/Prior Authorizations Submissions.

You should know or have reason to know that a service or item may not be covered if:

- We have provided general notice through an article in a newsletter or bulletin, or information provided on (including clinical protocols, medical and drug policies) either that we will not cover a particular service or item, or that a particular service or item will be covered only under certain circumstances not present with the Customer; or
- We have made a determination that the planned service or item is not covered and have communicated that determination to you on this or a previous occasion.
- For benefit plans, has published guidance, through National Coverage Determinations, Local Coverage Determinations, or other guidance, indicating that the service or item may not be covered in certain circumstances. You are required to review the Medicare Coverage Center available at . You must not bill our Customer for a non-covered service or item in cases in which you do not comply with this Protocol.

If, in accordance with the terms of this Protocol, you requested a pre-service organization determination and an IDN was issued before the non-covered service was rendered, you must include the –GA modifier on your claim for the non-covered service. Including the –GA modifier on your claim will help ensure your claim for the non-covered service is appropriately adjudicated as Customer liability.

You must not bill a Customer for non-covered services in cases in which you do not comply with the terms of the Protocol outlined above. Failure to comply with the terms of the Protocol, including but not limited to failure to request a pre-service organization determination for a Customer or rendering the service to a Customer before issues the pre-service organization determination, will result in an administrative claim denial. You cannot bill the Customer for claims that are administratively denied.

Customer financial responsibility

Customers are responsible for the copayments, deductibles and coinsurance associated with their benefit plans. You should collect copayments at the time of service. To determine the exact Customer responsibility related to benefit plan deductibles and coinsurance, we recommend that you submit claims first and refer to the appropriate Explanation of Benefits (EOB) or Provider Remittance Advice (PRA) when billing Customers.

However, if you prefer to collect payment at time of service, you must make a good faith effort to estimate the Customer's responsibility using the tools we make available, and collect no more than that amount at the time of services. Several tools on our website can help you determine Customer and health plan responsibility, including Claim Estimator (→ Claims & Payments → Claim Estimator) and the Eligibility Inquiry function, which shows HRA balances. (**Note:** Claim Estimator is available only for professional Commercial claims).

Some claims may be adjudicated in real time while the Customer is still in your office. After services have been rendered, you can use the claim submission feature on . Within seconds you will receive a fully adjudicated claim that shows the plan's responsibility and the Customer's responsibility, based on contracted discounts and plan benefits. This will help promote accurate collections and avoid overpayment or underpayment situations.

In the event the Customer pays you more than the amount indicated on the medical claim EOB/remittance advice, you are responsible for promptly refunding the difference to the Customer.

For Customers who are eligible for Medicaid, you will not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Customer, or his or her representative, or against the organization for Medicare Part A and B cost sharing (e.g., copayments, deductibles, coinsurance). You will either: (a) accept payment made by or on behalf of the organization as payment in full; or (b) bill the appropriate state source for such cost sharing amount.

THE COMMISSION'S POLICY IS TO POST ONLY THE FIRST FIVE PAGES OF ANY DISMISSED COMPLAINT ON ITS WEBSITE.

FOR ACCESS TO THE REMAINDER OF THE COMPLAINT IN THIS MATTER, PLEASE MAKE YOUR REQUEST IN WRITING TO THE COMMISSION ON JUDICIAL CONDUCT AND REFERENCE THE COMMISSION CASE NUMBER IN YOUR REQUEST.